

# **MID-TERM ASSESSMENT OF REDSO/ESA'S STRATEGIC OBJECTIVE 7: *ENHANCE REGIONAL CAPACITY TO IMPROVE HEALTH SYSTEMS***



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East and Southern Africa (USAID/REDSO/ESA)**

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## ACRONYMS AND ABBREVIATIONS

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|           |  |
|-----------|--|
| AFR/SD    | Bureau for Africa, Office of Sustainable Development (USAID)                           |
| AIDS      | Acquired Immuno-Deficiency Syndrome  |
| CDC       | U.S. Centers for Disease Control and Prevention  |
| CRHCS     | Commonwealth Regional Health Community Secretariat (now ECSAHC)                        |
| ECSA      | Eastern, Central, and Southern Africa  |
| ECSACON   | Eastern, Central, and Southern African College of Nursing                              |
| ECSAHC    | Eastern, Central, and Southern African Health Community (formerly CRHCS)               |
| EPI       | Extended program of immunization   |
| FHA       | Family Health and AIDS   |
| FHI       | Family Health International  |
| FP        | Family Planning  |
| FSN       | Foreign Service National   |
| FY        | Fiscal year  |
| ID        | Infectious disease   |
| IMPACT    | Implementing AIDS Prevention and Control Activities Project                            |
| IPPF      | International Planned Parenthood Federation  |
| IR        | Intermediate Result  |
| IRC       | International Rescue Committee   |
| ISP       | Integrated Strategic Plan  |
| M&E       | Monitoring & Evaluation  |
| M&L       | Management & Leadership Program  |
| MAC       | Malaria Action Coalition   |
| MAP       | Multi-Sectoral AIDS Program  |
| MIPESA    | East and Southern Africa Coalition for Malaria Prevention and Control during Pregnancy |
| MOH       | Ministry of health   |
| MOST      | Management and Organizational Sustainability Tool                                      |
| NGO       | Non-Governmental Organization  |
| NHA       | National Health Accounts   |
| PHN       | Population, Health, and Nutrition  |
| PIVA      | Partner Institutional Viability Assessment   |
| PMP       | Performance Monitoring Plan  |
| POLICY    | The Policy Project   |
| PSI       | Population Services International  |
| RBM       | Roll Back Malaria  |
| RCQHC     | Regional Centre for Quality of Health Care - Kampala                                   |
| REDSO/ESA | Regional Economic Services Office for East and Southern Africa                         |
| RH        | Reproductive Health  |
| RPM+      | Rational Pharmaceutical Management Project   |
| SARA      | Support for Analysis and Research in Africa  |
| SO        | Strategic Objective  |
| SWAPs     | Sector-wide assistance programs  |
| TAACS     | Technical Advisor on AIDS and Child Survival   |
| TB        | Tuberculosis   |
| WHO       | World Health Organization  |



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## EXECUTIVE SUMMARY

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The purpose of this assessment is to provide the United States Agency for International Development (USAID) Regional Economic Development Services Office for East and Southern Africa (REDSO/ESA) with an independent mid-term assessment of its Strategic Objective Seven (SO7) – Enhanced Regional Capacity to Improve Health Systems in East and Southern Africa.

The assessment was made during October/November 2004. Following interviews in Washington DC with selected staff of the Africa and Global Health Bureaus, the Team traveled to the field for meetings with REDSO offices in Nairobi, followed by site visits with Partner Organizations in Nairobi, Kenya; Kampala, Uganda; and Arusha, Tanzania. The three-person Team included specialists in public health, organizational development, and finance-management.

The Team found that the SO7 regional program is making headway towards achieving target indicators and results. Under each of the IRs, most of the indicators are either on target or surpass the established targets. Additional Team investigation supports these conclusions and indicates that the target results will be achieved within the remaining strategic period.

Findings indicate that REDSO/PHN's work with the three African Partner Institutions has been effective and should continue to be so. However, findings also indicate some areas that should be addressed to maximize the value of these Partnerships. Issues include perceived limitations to some partner agreements, the complexity and application of the PIVA tool, African ownership and shared visions, and levels of financial dependence on USAID and their implications.

Other issues include limitations to Partners' institutional viability; the relationships between REDSO/PHN, the Partners and the Cooperating Agencies, and strain on PHN staff between their administrative and technical support functions inherent in their roles as Activity Managers.

The nature of the sort of regional work that SO7 is involved in, along with influence from a number of external variables, make it next to impossible to measure the ground-level impact of the Regional Program. However, there have been significant accomplishments towards the objective of "enhancing the regional capacity to improve health systems." This is particularly noteworthy considering the extremely limited financial resources allocated to REDSO/PHN as compared to AID's bilateral PHN programs in the region.

Several successes cited are the regional assistance in health care financing, policy development that filters down to host countries and training programs such as RCQHC's Quality of Care training in priority health areas. An understudied and under publicized area where there may be considerable bearing on the Bilateral Missions is in the support that REDSO/PHN gives to a number of regional technical networks. A number of respondents saw the development of health systems networks as one of the major accomplishments of the Partners and REDSO/PHN.

A review of Better Practices (BPs) introduced in the Region by REDSO and its Partners show a steady increase in the numbers of new BPs introduced each year since the beginning of the current strategic period. Examples of SO7 contributions that impact on Ministries of Health in the region are: health policy reform; health care financing reform; technical training; and the development of guidelines and protocols.

Support to Missions and LPCs is demand driven, provided only as requested by Missions and the LPC Office. The LPC Office indicated that the services it received from REDSO/PHN were very satisfactory and that the quality of PHN services was very good. Regarding services to Missions, the Team found that they rarely used REDSO/PHN services, averaging about once per year per Mission. However, when services were rendered, REDSO/PHN staff were rated highly in terms of technical competence. Activity Managers feel they have insufficient time to provide meaningful assistance to Missions while servicing their Regional Partner organizations.

Missions had little or no knowledge of SO7's regional program or of the three Partner Institutions. Some expressed no interest while others want to know more.

The following is a prioritized and highly summarized list of recommendations that the MTR team feels are critical to the continued success of REDSO/PHN's program.

- 1) Review and decide on a selection of the following alternative management scenarios: a) adjust the current PHN management approach to increase synergy between the SO7 Regional Program and support services to missions and LPCs, and b) expanding the number of Regional Partners and engage the services of an institutional contractor to assume Activity Manager functions while PHN staff maintain technical oversight and support to the Partners.
- 2) Hire a Diffusion of Innovation Expert to develop a program for maximizing the diffusion of "better practices" and other health initiatives/innovations through existing communication channels.
- 3) Establish indirect cost rates with the Partners as soon as possible in order to maximize their potential to recover core costs from a broader resource base and, thereby, increasing their financial viability.
- 4) With respect to the future use of the PIVA, select from the following options: (1) keep PIVA and drop all/most other existing IR 7.1 indicators since PIVA covers them all; (2) drop PIVA, create one or two Governance indicators and add these to the other IR 7.1 Indicators; and (3) simplify the PIVA, in close collaboration with Partners, and stay with the other indicators.
- 5) Each Partner should dedicate twenty percent of a single staff person's time tasked to: a) identify indicators of program impact relevant to each specific activity; b) establish base-line data; and c) track and report on indicators to REDSO/PHN.
- 6) Secure the services of an experienced survey organization to revise, in collaboration with Partners, and administer the Institutional Leadership Survey in order to maximize response rates and the utility of results.
- 7) Develop, collaboratively, a clear, holistic, cohesive vision of the SO7 Results Framework, which offers all stakeholders more ownership of that vision.



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# **MID-TERM ASSESSMENT OF REDSO/ESA'S STRATEGIC OBJECTIVE 7: ENHANCE REGIONAL CAPACITY TO IMPROVE HEALTH SYSTEMS**

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## **INTRODUCTION**

### **PURPOSE**

The purpose of this assessment is to provide the United States Agency for International Development's (USAID) Regional Economic Development Services Office for East and Southern Africa (REDSO/ESA) with an independent review of progress achieved thus far under its Strategic Objective Seven (SO7) – Enhanced Regional Capacity to Improve Health Systems in East and Southern Africa. See Annex A for the Scope of Work (SOW) of the assessment.

### **BACKGROUND**

REDSO traditionally focused on providing technical and analytical support services to twenty-two countries (now 23) in ESA, while implementing limited regional activities. According to the SOW, starting in the mid-1990's, REDSO's approach changed to providing a combination of investments and coordinated efforts in bilateral, regional, as well as centrally funded programs. Its regional program emphasized strengthening African capacity to achieve food security and conflict management in the Greater Horn of Africa, and health and HIV/AIDS activities in all of ESA. REDSO shaped its regional program to closely conform to the principles of the Greater Horn of Africa Initiative (GHAI), which now underlie REDSO assistance efforts throughout the ESA region.

During REDSO's triennial review conducted in March 2004, USAID/Washington approved a two-year extension of the strategy through 2007 (completion date of September 30, 2008). In addition, USAID Washington approved a fourth SO (SO8): "Strengthened Programs for HIV/AIDS in the Region." This SO addresses HIV/AIDS through a multi-sectoral approach from a regional platform.

Since 1995, REDSO/PHN, which manages Strategic Objective No. 7 (SO7), has been working to strengthen and support an existing, African-initiated, regional approach to addressing regional health issues. REDSO/PHN is strengthening the capacity of African organizations to play a lead role in addressing regional health priorities. The SO7 team shares with the rest of REDSO the three mandates of managing a regional program, providing technical services to missions in the region, and supporting programs in limited presence countries. To achieve the first mandate, the SO7 team works with three principal partners – the Eastern and Southern African Health Community (ECSAHC; formerly CRHCS) in Arusha, Tanzania, the Centre for African Family Studies (CAFS) in Nairobi, Kenya, and the Regional Centre for Quality of Health Care (RCQHC) at Makerere University in Kampala, Uganda. Brief descriptions of these African partner institutions are found in Annex D.

REDSO/PHN provides support to the region in four areas:

- strengthening the institutional capacity and sustainability of regional partner institutions
- expanding the human, technical and program resources base available to improve health systems throughout the region
- increasing the analysis, dissemination, and application of information to enhance programs, and
- Enhancing the policy environment by improving regional dialogue on regional policy issues in key technical areas that include HIV/AIDS, maternal and child health and nutrition, reproductive health, infectious disease, and health care financing.

These four areas correspond with the four Intermediate Results (IR's) REDSO identified to achieve the SO7.

## **METHODOLOGY**

The Scope of Work (SOW) includes four tasks. The Mid Term Review (MTR) Team took the approach in this report of using Task 1 to assess the SO7 Results Framework in so far as its adequacy in capturing the true nature of the SO7 program, the progress REDSO/PHN has made to-date in achieving the desired results and the feasibility of REDSO/PHN achieving the desired results within the remaining strategic period. Task 2 examines REDSO/PHN's approach to working with the African Partner Institutions and its efforts to build their institutional viability, capacity, and capability. Task 3 looks at technical capability needs in the region and the extent to which REDSO/PHN's program has and is able to enhance technical capacity to meet those needs. The approach taken for Task 4 was to see the extent to which REDSO/PHN has the structure and resources to be able to balance the 3 separate mandates of building regional capacity, supporting the USAID Bilateral Missions as needed, and responding to the emerging needs of countries where USAID has no or little in country presence.

The Team used the following methods for data collection: 1) Interviews with staff from the Africa and Global Health (GH) Bureaus at AID/Washington and select staff from REDSO; 2) 37 key informant interviews with REDSO/PHN and other REDSO staff, staff from the 3 Regional Partner Institutions, staff members of relevant Cooperating Agencies (CAs), as well as PHN staff from several ESA bilateral missions; 3) in-depth interviews to obtain more detailed information on particular subjects; 4) extensive document review, and 5) internet research.

The four tasks described in the assessment workplan guided the methodology used by the Team over the four week period of investigation. The team first reviewed key documents and conducted brief interviews in Washington DC with selected staff of the Africa and Global Bureaus. The team then moved to the field for meetings with REDSO offices in Nairobi, followed by site visits with Partner Organizations in Nairobi, Kenya; Kampala, Uganda; and Arusha, Tanzania. The team concluded the assessment process by sharing draft findings with REDSO prior to departing Nairobi. The Team then finalized the assessment document, incorporating Mission and USAID/Washington comments.

### ***Key Informant Interviews***

The Team used a key informant interview tool to interview approximately 41 persons – at times with two or three individuals together –, including the staff of REDSO's PHN Office, the PHN units of selected Bilateral Missions, representatives of the limited-Presence Missions, the three Regional Partner Institutions, and others with knowledge of the SO7 program. The key informant interview format allowed the Team to capture consistent information from a wide range of specialists from numerous institutions.

### ***Directed Interviews***

The Team used directed interviews to obtain in-depth, detailed knowledge of a particular subject, usually as follow-up to the more general key informant interviews described above. The interviewer followed a topical outline of issues/questions to be discussed with those most familiar with the subject matter. Topics included AID financial accounting/management with respect to PHN grantees, project management and monitoring by PHN, Bilateral Mission perceptions/use of REDSO PHN services, among others.

### ***Site Observation***

While brief, site visits were made to Partner institutions in Nairobi, Kampala, and Arusha. Because of the brevity of these visits, Team members were unable to observe detailed operations of each Partner. Nevertheless it was useful to observe overall management organization practices of the Partners. It is important in this context to note that the Team made no end-user site visits or interviews because of time constraints. The Team considers this to be a limitation of the assessment, since it was unable for the most part to empirically track the impact of the Strategy out to those most benefiting from it.

### ***Review of Documents***

The Review team received a briefing packet of materials sent from the REDSO/PHN office prior to departure and began to read through these documents before leaving and on the trip to Nairobi. Upon arrival, the Team received additional documents from the REDSO/PHN office and collected additional documents, both electronically and in hard copy, throughout the review. The Team also collected information and documents from various relevant websites. A complete list of documents used is included in Annex B.

## **ORGANIZATION OF THE REPORT**

The remainder of the report includes, first, a brief overview of REDSO/ESA's most recent annually reported achievements under SO7 and a brief note on measurement issues. This is followed by a descriptive analysis of SO7 organized primarily along the four tasks outlined in the SOW. Each of the four tasks is further subdivided into sections including findings, conclusions, and recommendations. These sections are then followed by brief sections on lessons learned and a summary of prioritized recommendations. A series of annexes reflect materials referred to in the main text of the report.

## **BRIEF OVERVIEW OF REDSO/ESA ACHIEVEMENTS UNDER SO7 AND A NOTE ON MEASUREMENT ISSUES**

As reported in USAID/REDSO FY 2004 Annual Report, East and southern Africa public health systems are “already overburdened” and “unable to cope with the growing threat of resistant malaria strains, other endemic diseases and unacceptably high rates of maternal child mortality.” In this context, SO7 is integral to the REDSO mandate to enhance the capacity of African regional institutions to improve their public health systems. Beneficiaries of SO7 achievements are the Partner Organizations which are the object of the assessment. Indirect beneficiaries include people affected by regional conflict and especially women and children, who suffer an enormously high mortality rate and are thus considered to comprise the most vulnerable populations in the region. It is noted that efforts to reduce the spread of HIV/AIDS are organized under a separate REDSO strategy, and are thus not the subject of the present assessment.

Key achievements for the reporting period FY 2004 relevant to SO7 are improved knowledge, management capacities and operational systems of African regional health partners. Examples of progress include the training of an additional 541 key professionals in areas such as hospital administration; operations research; fund raising; nutritional advocacy; malaria prevention and control; facilitative supervision in maternal and neonatal health; and performance improvement for antenatal care services – bring the total to over 1,500 people trained through the Regional Program since the beginning of the current strategic period.

SO7 Partner organizations are also attributed with having assumed greater roles in professional networking. Areas influenced by such networking are, for example, family planning and reproductive health, human resource development, and tuberculosis infection prevention and control. Additionally, Partners made strides in dissemination of state-of-the-arts information and best practices, for example, in health sector reform and national health accounts. In the public health policy arena Partner accomplishments include regional policy dialogue that promoted country-level attention to such critical areas as prevention and control of malaria during pregnancy and care and management of tuberculosis patients.

In the domain of leadership in addressing health issues, regional partners exceeded their targets in training and networking activities aimed at facilitating the implementation of state-of-the-art approaches. Partners also reached their targets in the area of promoting regional policy dialogue on priority health issues. In coordination with other donors, one of the regional Partners facilitated the acceleration of malaria control activities for pregnant women. Another Partner coordinated with WHO in developing a regional policy document on infection prevention, resulting in incorporation of policies and guidelines into country public health programs. Yet another Partner leadership achievement is the priority accorded to mainstreaming gender reproductive health service delivery. This was accomplished through regional stakeholder design, pre-testing, and completion of the *Gender and Sexual and Reproductive Health Integration Guide* intended for Ministries of Health (MOHs) and NGOs.

Major achievements of African Partners include their increased leadership in dissemination of technical information and development of approaches and materials to improve health program and system quality of countries in the region. One clear result in this domain is that Partners significantly exceeded their target in the dissemination of better practices across the region. In

the critical arena of health financing, regional Partners greatly energized the regional dialogue on expanded coverage of basic services to the poor through informal risk-pooling schemes.

Other important achievements by regional Partners occur in regional health professionalization, notably in broadening the base of skilled African health specialists who can share their expertise throughout the region. Training of such skilled professionals exceeded its target, thus expanding the base of such persons who can share their knowledge and skills to help countries in the region improve their health program and systems.

Yet another area of accomplishment under SO7 is improved Partner institutional leadership in networking activities aimed at improving health systems in the region. Drug management systems enhancement is one of the important arenas where such leadership paid off. Practical guidelines for the quantification of drugs and medical supplies needs were developed, which will result in the reduction of “chronic and widespread shortages of drugs in the health system and improve the efficiency of existing resources at all levels of care.”

The FY04 Annual Report points to the role of SO7 in institutional strengthening of Partner regional organizations that have directly supported improved health systems capacity. Critical to such strengthening is in the areas of management and leadership. Improved strategic and annual planning in particular are especially important in this respect. A specific challenge noted in the Report is the need to balance organizational strengthening against technical program growth. Such a challenge is not only organizational in its scope, but heavily implicates funding availability.

An important caveat to the present assessment concerns the issue of measurement – to assess the adequacy of SO7 presents myriad measurement constraints, especially given the nature of the Regional Program and limit on time to visit, observe, and interview Partners, much less even to survey a small sampling of some end-users of the intended improvements in health system capacity. While this assessment is more focused on qualitative change, it still must grapple with certain quantitative measures. The assessment will clearly note when this issue arises.

## **TASK 1: ASSESS PROGRESS TO-DATE TOWARDS ACHIEVING SO7 RESULTS**

*Aim: To establish whether current REDSO/PHN supported and financed activities are the right ones to achieve the results outlined in the approved results framework*

### **FINDINGS**

#### ***Adequacy of Results Framework as a Plan for Achieving Results***

The Results Framework for SO7 (see Annex E), “Enhanced Regional Capacity to Improve Health Systems,” is comprised of four Intermediate Results (IRs):

- IR 7.1 Improved Viability of Regional Partner Institutions
- IR 7.2 Broadened Technical Resource Base
- IR 7.3 Expanded Utilization of Critical Information
- IR 7.4 Expanded Policy Dialogue

In assessing the Results Framework (RF), two questions arise: (1) do the indicators adequately measure progress towards the four IRs, and ultimately the SO, and (2) is the RF effectively used to actually guide implementers in achieving practical, measurable results for use in managing activity and overall program results?

Answers to these questions derive in part from recent partners meetings, during which participants discussed the efficacy of SO7 indicators and suggested changes in specific indicators. One such suggestion was to move the Leadership indicator to the institutional viability IR and replacing the Financial Plan indicator with another indicator. As a result of those meetings REDSO/PHN staff plan to make revisions, modifying several indicators and adding three new ones. The Team findings on the RF and specifically on indicators follow directly.

The Participatory Institutional Viability Rating (PIVA) used to measure IR 7.1 appears to provide a solid conceptual framework and useful guide to organizational development/viability, very similar to the Organizational Development (OD) tools used elsewhere in the developing world and the US, such as the Management and Organizational Sustainability Tool (MOST) developed and used by MSH and the Elements of an Effectively Managed Organization (EEMO) tool developed for NGOs in the US.

The Team believes the Leadership Survey is a useful tool in measuring public perception regarding the Partners. The positive perception evidenced in this Survey is an important measurement of an organization’s credibility. However, the most recent response rate to the Survey was only around thirty-three percent, which raises concerns as to the utility of the instrument as it is currently being administered.

One of the three new indicators recently proposed is perhaps the most critical – the leveraging of other donor funds. As it is now defined, the new indicator would measure “percentage of total program support funded by other donors, host-country governments and partner agencies.” The Team agrees that leverage for total program support shows how other funding sources are making use of Partner services. At least as important, however, is to measure the leveraging for

core funds, allocated to key staff and operating costs incurred by a Partner and essential for its operation.

The RF should not only be a conceptual guide but it should serve also as a guide to achieving results in practice - to be used to effectively plan, implement, and manage activities directed to achieve specific results.

The Assessment Team found a high degree of familiarity with the SO7 framework among those key informants who are active in planning, implementing and monitoring SO7 activities – PHN staff, staff from the Regional Partner Institutions and representatives from various cooperating agencies (CAs). One Partner, ECSAHC, demonstrated its familiarity with the RF by using it in presenting its Strategic Plan for 2004-7.

The Strategic Framework and Performance Monitoring Plan (PMP) were discussed in some detail at the recent Partners Meeting, held in Entebbe on October 18 - 20. The Team received positive feedback regarding this meeting. The Partners and CAs felt that the meeting provided them with a clearer understanding of the framework than they had in previous years. This was reflected in the Partner and CA draft work plans, produced out of the meeting, all of which identify the relevant indicators, targets, and intermediate results for each activity to be implemented over the following year.

It was not clear to the Team, however, whether the framework will be used by the stakeholders (Partners, CA's and REDSO/PHN staff) on a ongoing basis as a management tool for calibrating achievement and for making course corrections where necessary or whether it is seen as a way of fulfilling USAID required annual work plans and reporting. When asked about weaknesses of the SO7 Program, a large number of respondents stated that it lacks 'overall vision'. This indicates that, while the Framework defines specific components of the Program, it is not providing many stakeholders with a clear understanding of what the overall Program intends to achieve. Without providing that 'vision' the Framework cannot be an effective tool for planning within the broader picture.

One of the PHN staff expressed that, as plans change through the course of a year, Partners sometimes propose activities that do not contribute to the results framework and that it can be difficult to get them to see the necessity to do so. This further shows that, while there is familiarity with the RF as a planning and reporting document, there is also a lack of clarity as to its effective application throughout program implementation. A significant point here is that, while participating Partners gave input when the current SO7 Framework was originally designed, there has been significant change in Partner staff since its inception four years ago.

### ***A Brief Overview of SO7 Progress to Date***

The following represents an effort by the Assessment Team to track results under the SO and IRs. Given constraints on time in the field and issues of measurement raised earlier, it behooves us to note that the following progress report is representative and indicative of achievements to-date and is in no way complete. Progress reported is considered for each IR.

### **IR 7.1 Improved Viability of Regional Partner Institutions (Partners)**

The three Partners have shown progress in addressing the key components of organizational development. PIVA baselines are now developed, and the tool is being used to establish OD work priorities. Partners have developed strategic plans and annual work plans. Personnel and financial management systems are now largely in place and are functioning reasonably well. Partners are at different stages of PIVA-defined institutional viability, and each seems committed to undertaking completion of specific steps toward viability as identified, usually in consultation with REDSO/PHN and the CAs. Their priorities are appropriate for their respective stages of development. Also, one Cooperating Agency, MSH through its Management and Leadership Project (M&L), is assisting the Partners in most of their OD related tasks. Financial Planning (Indicator 7.1.3.1) results have not yet been fully achieved as they rely on other aspects of core operational systems to be established first. However, it was reported to the Team that this financial aspect is ready to be addressed and will be done so through the preparation of Business Plans, to begin in the coming months.

Another issue concerning Partner viability is staffing and the ability to retain the necessary technical skills to implement activities. Having full-time technical staff on board means having to pay full salaries, whether or not those individuals are covered under contracts, which ultimately raises an organization's core costs. An alternative that the Partners use to varying degrees is to work with consultants. However, the Team found a number of constraints to this approach, including a limited regional consultant pool, difficulty in competing with larger firms that are able to pay consultants higher rates, and the Partners' ability to manage consultant assignments efficiently. It was suggested that in-depth analysis of these issues should be conducted as part of the process of developing the Partners' Business Plans. Another approach would be to explore the development of some of the various networks that have been established into mechanisms for consultant recruitment and placement.

## **IR 7.2 Broadened Technical Resource Base**

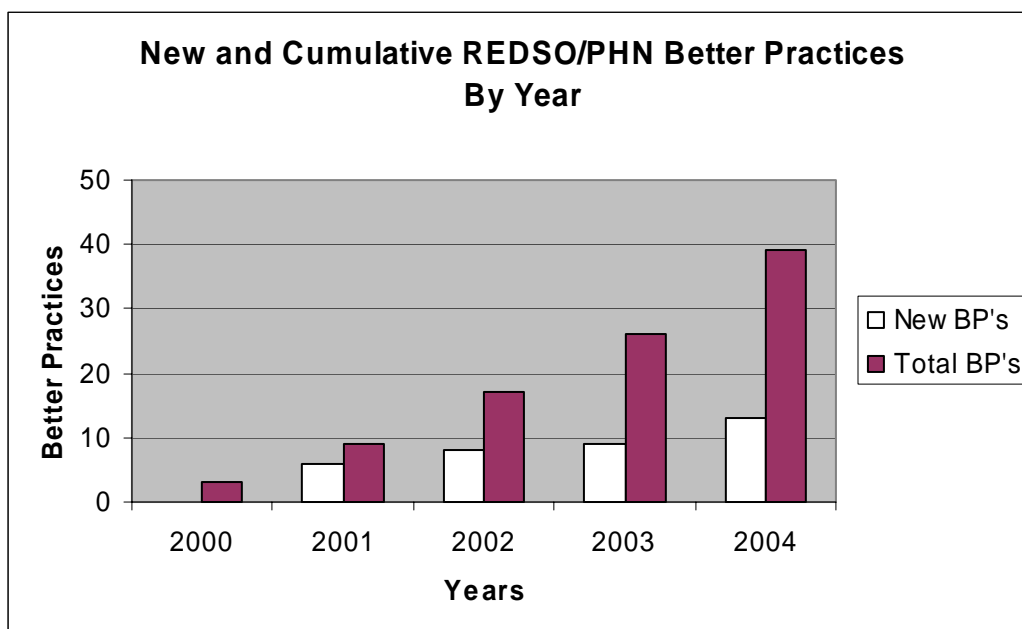
Through technical training and networking activities, CAFS and the other Partners have done a great deal towards expanding the base of African specialists skilled in improving health systems. Through the Regional Program there is a growing technical base, particularly at ECSAHC. As indicated by USAID staff, Partner activities that handle small numbers of trainees at a time, such as the RCQHC Diploma course, "concentrate on specialist skill areas that are needed and not generally catered for in the regular curricula of nursing and medical schools (or other training institutions). Training up to 20 mid or senior level specialists in managing quality (assurance) programs may be significant providing the staff return to work in the design and implementation of national programs in improving quality. In drug management, for example, the training of only 2 or 3 country staff in improved commodity quantification can have a significant impact if the training is applied properly." As indicated later in Task 3 of this report, what is necessary is increased attention on the monitoring and follow-up with these trainees in order to better observe the ground-level effectiveness of such programs. Another problem facing the region is the continual loss of nurses, midwives and other service providers. Some of the reasons suggested for this include inadequate salaries, lack of an enabling environment, death of skilled staff due to HIV/AIDS and the difficulty in replacing them. It was suggested that a Training of Trainers (TOT) approach at the regional level might be one way to address this issue.



Also under IR 7.2, a number of respondents cited the Regional Program's considerable network activity as a great success. But, the cost of maintaining active networks at an adequate level seems to be greater than available resources.

### IR 7.3 Expanded Utilization of Critical Information

There has been significant progress in the operationalization of 'Better Practices' - practices shown to be appropriate for Eastern and Southern Africa. REDSO/PHN, the Partners have contributed to the introduction of some 39 'Better Practices' (see Annex G) which should be seen as success stories for the Region (National Health Accounts being the most prominent example). The chart below shows the accumulation of REDSO/PHN Better Practices over time and clearly shows the progress that has been made since the beginning of the current strategic period.



As stated by PHN staff, “many of the system level changes that are being implemented are recognized good management practices in their own right – NHA for resource management at national level, down to inventory control at service delivery point, with well developed procedures, producers’ guides and foted tried and tested computer based software. Clinical best practices are the results of extensive trials and testing with the endorsement of agencies such as WHO, UNICEF and USAID. Based on earmarked funding, and regional interest of partner organizations, as well as dialogue within the technical working groups, best practices are selected, field tested and replicated.” In addition, the staff also indicated that they are exploring the option of piloting new Better Practices in two or three countries before promoting them on a regional level. However, there does not appear to be a systematic mechanism for maximizing the dissemination of appropriate Better Practices, which could only increase the progress SO7 is already making in this regard.

### IR 7.4 Expanded Policy Dialogue

The Team avers that IR 7.4 has the best prospects for being achieved considering available resources. This is because of the viability and apparent sustainability of ECSAHC which

spearheads policy development. Its access to the Ministers of Health facilitates the diffusion of system-strengthening approaches throughout the region. The tremendous leveraging effect that a relatively small investment by REDSO/PHN has on influencing health-system agenda-setting in Eastern and Southern Africa is, perhaps, one of the most profound contributions of the REDSO/PHN initiative. Examples include the incorporation of gender in reproductive health and TB programs; the removal of taxes on imported insecticide-treated nets (ITNs) to address the major constraint that cost places on people's ability to purchase these effective means of preventing malaria; the adoption of community based health funds (CHF) to expand coverage of basic services to the poor; and regional working groups on food fortification that have developed a one year work plan to enhance regional fortification activities that will be operationalized in FY 05 to provide enhanced nutritional status to large proportions of the populations in participating countries.

## **CONCLUSIONS**

The Regional Partners are familiar with the SO7 Framework and use it, to varying degrees, as a guide to program implementation. Certain indicators need to be modified and/or added and most of these are already under discussion among PHN and Partners. PHN/Partners are aware that they should pay particular attention to the financial indicators of viability; achievement of these will ensure the survival of the institution, at least at some level, once AID funding is terminated. An organization achieves financial self sufficiency when it has sufficient annual income - derived from its constituency (e.g. membership dues), from its customers/clients (e.g. fees for services and overheads) and/or from long-term external sources (e.g. trust/endowment) - to fund its core operational expenses and maintain a minimum level of services valued by its customers. In short, an organization is financially self sufficient when it has enough income for it to survive, albeit with reduced staff and programs, while it searches for longer-term solutions to a financial squeeze caused by external or internal factors. This type of organization can expand services when times are good (donors plentiful, positive economic/political environment, etc) and reduce services when times are bad.

The PIVA indicator is conceptually sound and comprehensive but needs to be simplified, drawing attention to the most important components of viability and making it more user-friendly.

The value of the Leadership Survey in measuring perceptions of the Partners should not be underrated. However, the response rate needs to be increased to maximize the credibility and utility of results and carried out if partner institutions continue to value it.

PHN staff, Partners and other key stakeholders should continue to keep the RF alive and on the table for discussion and modifications as appropriate. More attention should be given to creating a clear vision of where the RF is leading stakeholders. What do they hope will exist by the end of FY07 in terms of strengthened institutions, networks, and technical outputs?

The relatively modest budget of REDSO/PHN compared to most bilateral missions in the region reflects well on REDSO, given the level of its accomplishments. While significant accomplishments have been made, questions remain about the ultimate impact of SO7 on health status. Such impact is presently beyond the manageable interest of SO7. The nature of the Regional Program, which seeks to strengthen *regional health systems*, is such that the country level or people level impact of SO7 accomplishments involves a number of external variables

outside SO7 control. Nevertheless, it is clear that some strategizing is necessary to obtain a sense of the end game.

Stakeholders have made a good start and are now using the RF, but PHN and the Partners should develop a way of making performance management integral to the implementation of all activities and programs. While work with M&L is addressing this to some extent, as can be seen in Partner work plans that identify specific intermediate results and target indicators for all activities, it is clear that more needs to be done in order to reach a more comprehensive understanding of the overall SO7 vision.

## **PRIORITIZED RECOMMENDATIONS**

- 1) Given that there is no systematic mechanism for doing so, it is recommended that SO7 Hire a 'Diffusion of Innovation Expert' to develop a program for maximizing the diffusion of "better practices" and other health initiatives/innovations through existing communication channels. A Diffusion of Innovation Expert examines a number of aspects of a potential innovation. In this case, we are discussing the Better Practices REDSO/PHN is focusing on distributing throughout the ESA Region. The Expert examines these aspects and suggests way to manipulate them to accelerate and maximize diffusion of new ideas or practices. The ten aspects of innovation diffusion often identified are: relative advantage, trialability, observability, communications channels, homophilous groups, pace of innovation/reinvention, norms, roles, and social networks, opinion leaders, compatibility, and infrastructure.
- 2) To address the need for the Leadership Survey to ensure higher response rates, it is recommended that an experienced survey organization be hired to amend the tool as necessary and to administer the revised survey every two years. While in the interest of continuity, critical items should be maintained as much as possible, the instrument should be reviewed and refined in terms of the appropriateness of its questions, its general presentation, its user-friendliness, and the way it is administered, in order to maximize response rates and the utility of results. Partners should be consulted in the revision process so that the Survey provides information most useful to them.
- 3) It is proposed that the SO7 team develop a clear, holistic, cohesive vision of the RF that ties all the pieces together and to better communicate that vision with the stakeholders. This could, perhaps, be achieved by engaging them in an activity where, as a collective group, they develop that picture – defining what they see an "enhanced regional capacity to improve health systems" looks like. This 'vision development' activity could be introduced at next year's Partners Meeting, following a refresher presentation of the RF and PMP (including any revisions made as a result of this year's Partners Meeting, recommendations from this Mid-Term Review, and any new Agency guidance on standardized indicators). The Vision Development activity should consider the principles of the GHAI. The benefit of such an activity would be two-fold. First, involvement of current Partner staff in developing the vision will not only give them more understanding of its nature but will also give them a greater sense of ownership of it and, therefore, a greater sense of commitment to working within the Framework when planning and implementing activities. This, in turn, will all lead to a more effective application of the RF as a tool for ongoing activity management and direction, as opposed to being just a

periodic planning and reporting document, which will offer the Regional Program more cohesive definition.

- 4) Given the key of financial self-sufficiency to achieving institutional viability and its importance to any exit plan, in addition to the lack of clarity expressed by some of the Partner staff, it is proposed that the Business Plans being developed in the coming months include an explicit definition of financial self-sufficiency, customized for each Partner, and a plan of the steps needed to achieve that. REDSO/PHN needs to provide guidance on this, particularly as its current funding role ranges from sole provider for one organization's core and program costs to being a significant donor for another organization's activity costs (as opposed to core staff/operations). However, it is also important that Partners be heavily involved in developing that definition as it is critical to their sense of vision and ownership.
- 5) The Team recommends that a Training of Trainers (TOT) approach be further developed for addressing staffing shortages in the area. This might apply to such programs as the ESCACON. Another small course, similar to the RCQHC Diploma course, could be designed to focus on developing people who could lead regional TOT programs. While not necessarily addressing the root causes of staff shortages, which are beyond SO7's manageable interest, TOT is a cost effective approach that can still achieve significant levels of success in such a context.

## **TASK 2: REDSO/PHN'S MANAGEMENT APPROACH TO WORKING WITH AFRICAN REGIONAL INSTITUTIONS**

*Aim: To establish whether REDSO/PHN's approach to working with African partner institutions is the most effective one for achieving the goal of improving health systems in the region or if modified or different approaches would be more effective.*

### **FINDINGS**

#### ***An Overview***

There is rationale that strengthening of the three Regional Partners could lead to enhanced regional capacity to improve health systems. As indicated in Task 1 and Task 3, their activities have already contributed to the other three IRs of a Broadened Technical Resource Base, the Expanded Utilization of Critical Information, and Expanded Policy Dialogue. A key informant expressed it best when she said that ECSAHC focused on agenda setting, policy generation and diffusion within the region, and efforts to have policy implemented at the country-level. She viewed RCQHC as operating at the institutional level in the training of health professionals, and the development of State-of-the-Art approaches to Quality Health Care through curriculum development, workshops, and continuing education. She saw CAFS as focused on the community level and how programs could be designed to make them family-friendly and family-useful. CAFS' main focus has been on Family Planning and Reproductive Health. Thus, their relatively different mandates suggest the potential for the Partners to work in concert, not in competition, to advance achievement of the SO7 Strategic Objective.

The high visibility of ECSAHC and CAFS and their considerable network means that SO7's initiatives build rapid links to Ministries of Health, to service providers, and potentially to the community. RCQHC is actively developing its technical networking ability, and already has established some links to MOH decision makers such as through MIPESA, whose current chairperson is the Head of RH services in Zambia. The Centre and CAFS also offer significant contributions through their capacities in education and training.

With regard to the viability/sustainability of the Partners, It appears that there is little duplication of staff functions within each of the three Partners. This means that the departure of a staff member can create a gap in that organization's ability to address contractual responsibilities and/or to carry out day-to-day functions. On the other hand, the three organizations have overlapping technical personnel, which would suggest that they are in good position to work together on developing policies, standards, and programs of mutual interest. This is reflected in their Memorandum of Understanding MOU of March, 2002. While the Partners positioned themselves at different organizational levels, the MOU indicates that they employ similar strategies (training, technical assistance, networking, and publications) to achieve their objectives.

#### ***The Partner Agreements***

CAFS operates under a Cooperative Agreement with REDSO and the RCQHC and ECSAHC have Limited Scope Grant Agreements (LSGAs) with REDSO.

CAFS is satisfied with their funding instrument and felt that the Cooperative Agreement enables them to develop long-term plans and budgets with relative confidence in the availability of funds from one year to the next. The Cooperative Agreement also allows CAFS to negotiate an indirect overhead rate with USAID, which offers an alternative mechanism to recover core costs instead of billing directly for these costs.

Several respondents from ECSAHC and RCQHC, however, cited limitations to their LSGAs. They mentioned the following:

- LSGAs do not permit longer range (beyond one year) funding/planning and this has negative consequences such as RCQHC staff contracts (where REDSO funds all staff) that cannot exceed one year,
- LSGAs increase the documentation workload for both Partners and PHN staff (ILS, action memos, amendments, etc.), and
- One Partner staff person saw LSGAs as a REDSO tool to oversee Partner performance, giving REDSO the option of opting out or otherwise exerting pressure if Partner performance was less than anticipated.

Partners generally believe that the multi-year funding/planning horizon that they associate with Strategic Objective Agreements (SOAGs) would be a benefit to them. They also feel that SOAGs would allow them more leeway/ flexibility in reprogramming funds, require less paperwork and less REDSO oversight. Use of SOAGS would provide them with a more secure environment for program planning and implementation.

Some PHN staff echoes some of the concerns regarding the LSGAs, also citing the high documentation workload, oversight demand and difficulty in developing activities in a strategic way. PHN has put the possibility of moving to SOAGs on the table in their discussions with Partners and is actively exploring this option.

### ***Funding the Partners***

The funding mechanism is rather complex and can be confusing. It appears that the Partners do not fully understand the process of funding from AID through REDSO. Frustration was expressed by some REDSO staff with the capacity of the Partners to respond to USAID financial requirements. One specific example is the annual audit. RCQHC is one year behind on its financial audit. When asked why, the Centre explained that they were without an accountant for several months and the new accountant has only been there for seven months. It takes time to learn the USAID system so it is difficult for a new individual to come in fresh and carry out all the necessary functions. This issue of staff turn-over is not insignificant for the Partners and is one that should be addressed if they are to be truly viable and able to weather staffing problems.

A number of the respondents saw the development of networks in East and Southern Africa as one of the major accomplishments of the Partners and REDSO/PHN. They also feel that the maintenance of these networks is a time (and resource) consuming activity, and that the networks would benefit from more funding to maximize their impact and viability. There might be some advantages to linking monies spent on technical assistance (TA) with the networking process so that enhanced network development might lead to more use of East and Southern Africa-based consultants.

Some Partner staff indicated in their interview responses that funding is adequate for the activities they are tasked with. This is further reflected by the pipelines that exist in some of the Partners' budgets. The issues lie in their ability to move these funds and having the flexibility to reprogram them as work plans change through the course of a year. Several respondents also commented that CAs are sometimes held back from conducting certain tasks because all of their REDSO funded activities must be carried out in collaboration with the Partners and the Partners are not always able to deliver on time their participation in these activities.

### ***African Ownership***

African ownership is greatly enhanced when Africans pay for the core staff and operating costs of an organization. The Partners recognize that they must have the ability to receive and be accountable for increased funding. They seem committed to the process. ECSAHC is the best example of such ownership and the exercise of independent decision making. ECSAHC has strong governance by the Ministers of Health in the Region and the Ministries pay core organizational costs. The RCQHC, on the other hand, is funded almost solely by REDSO and is very susceptible to REDSO influence over a range of program and internal organizational issues. Weak African ownership, in this case, is exacerbated by the exercise of little governance by its practically non-functioning Advisory Board and unclear linkage to Makerere University. There obviously are advantages of being a closer part of a university with an international reputation.

### ***Shared Visions, Goals and Priorities***

Most of the interview responses regarding shared visions, goals and priorities between REDSO/PHN and the Partners were positive. All three Partners have the goal of institutional viability. However, their particular vision of what that means beyond, for instance, the quantifiably measurable achievements captured through the PIVA tool, may not be the same as REDSO/PHN's vision for where they see the Partners in 2007. Respondents did not express that these were so much different as ill-defined. This goes back to the earlier concept of developing an 'overall vision.'

Priorities are also difficult to always keep consistent between SO7 and the Partners as priorities can be influenced by external factors such as funding sources. REDSO/PHN is not even in complete control of its priorities as it must work within the boundaries of funding earmarks as allocated by AID/Washington. The development of the Partners, and their commitment to undertaking the work they do as part of SO7 reflects a degree of shared priorities. However, it was expressed by a number of respondents that there is not always total agreement on how particular funds should be spent once obligated to the Partners. This is not necessarily a problem area. Differences in opinions regarding priorities can occur. In these instances it is important to maintain dialogue to collaboratively come to a consensus as much as possible, which gets to the Partners 'access' to SO7 staff and their responsiveness in managing partner expectations.

### ***Managing Partner Expectations***

The Partner expectations of the Centre for African Family Studies (CAFS) and those of The Eastern and Southern African Health Community (ECSAHC) – the old Commonwealth Secretariat are different than those of the Regional Centre for Quality Health Care (REQHC)

The latter is more dependent on REDSO for funding and guidance since it is much younger as an institution and has been nurtured to a far greater extent than the others.

Still, Partner interviewees mostly expressed a great deal of satisfaction regarding opportunities to communicate with and express their particular needs and expectations to the SO7 staff and the responsiveness that they received. PHN Grant Managers are in constant communication with their respective Partners via email, phone and regular visits so there are numerous opportunities for dialogue. As mentioned previously, the recent Partners Meeting was cited by many of the respondents as a very successful activity and they appreciated the venue to speak openly and collaborate as a team on setting directions for the regional program.

### ***The PIVA***

As mentioned in Task 1, all sub-IR 7.1 level indicators are captured in the PIVA as are other indicators, such as governance, that not covered explicitly in the Framework. It provides a comprehensive conceptual framework and guide for organizations that are trying to achieve greater viability as well as for donors trying to assist in this area. The Partner organizations have, in varying degrees bought into the process and expressed an understanding of its utility as a tool to help them improve their organizations' capabilities. However, there appears to be a good case for simplifying the PIVA.

The PIVA has 116 sub-indicators that must be considered as it currently being applied. It takes a great deal of PHN and Partner staff time to address and track these items. PIVAs are currently reported upon in narrative form every two years. REDSO recently translated the narrative into a numerical rating to indicate where a Partner is in the four stage continuum from Start-up to Mature organizations. Nevertheless, the 116 indicators must be tracked and at intervals more frequent than every two years. Developing the PIVA baseline is a particularly tedious and often contentious process. For example, one Partner still only has a "draft" PIVA baseline. Its staff is reluctant to proceed further because of the acrimony (reportedly both within the Partner organization and between REDSO and the Partner) that arose when the PIVA was first introduced a few years ago. It was characterized as being introduced in a top-down fashion rather than in a way that encouraged ownership by the Partner. Undertaking OD is particularly difficult and sensitive. It requires transparency (hanging out one's dirty laundry) and a high degree of motivation/commitment by all key players to a lengthy process of analyzing the inner workings of an organization. When foreign donors, who often hold the purse strings, get involved, the exercise becomes even more challenging.

Despite these difficulties, the Partners feel that the PIVA exercise has been very useful, though at times "brutal." However they would like it to be simpler. It is already moving in this direction. PIVA is now conducted every two to three years, with one or two of the subcomponents reported on annually. Its 116 sub-indicators should be reviewed annually, after which, Partners select the priority OD areas that need attention and include relevant activities in their annual work plans to address these concerns.

### ***Working with Cooperating Agencies***

Each year USAID's Global Health Bureau (GH) in Washington circulates a catalogue of current global contracts with cooperating agencies that can be bought into for service delivery related to



a Mission's particular program. In the development of REDSO/PHN's annual work plan, the SO7 staff review the catalogue for relevant contracts that could be used in support of their activities with the African Partner Institutions. Over the past three years of the current Strategy Period, SO7 has bought into over 20 (down to under 15 in 2004) of these programs allocating approximately 16 million dollars, or 64% of the total REDSO/PHN budget, to these programs.

One of these buy-ins has been used to specifically address organization development (OD) in the African Partner Institutions – the Management & Leadership Program (M&L). Services provided by the others CA's contracted by SO7 through GH have been for building Partner technical capacity or to build Partner technical capacity indirectly while achieving other SO7 results by working with them on joint activities. The latter activities are implemented by the CA's in collaboration with the Partners with the intention that the Partners will garner the knowledge and skills to implement the activities on their own in the future.

### ***Progress towards Institutional Viability***

#### **The Center for African Family Studies (CAFS)**

In a meeting in 2002, CAFS indicated that it was "undertaking several activities such as development of new courses and programs; bidding for projects; aggressive marketing of its products and services; and planning for a building project and an endowment fund ("Towards CAFS sustainability", Nairobi, 23rd July 2002). CAFS now appears well on its way to institutional viability. Some USAIDs in the Region now use CAFS' services.

CAFS has dramatically increased other donor contributions, reducing USAID's contribution to approximately 25% of its total donor receipts. It was indicated that this number may be slipping backwards a little, with reasons cited including increased competition for scarce resources and difficulty reaching the private sector level because the health field is largely donor dependent. In addition, CAFS now has an established NICRA with USAID that helps recover core costs. However, respondents from both CAFS and PHN indicated that, at times, they are still unable or unwilling to apply these particular indirect rates to their other clients – either applying lower rates or no rates at all. Some suggested that this is because of their need to be cost competitive in a resource strapped market and others suggested that it is because they do not stand strong enough when negotiating with their other clients. Either way, the results are that USAID continues to cover a disproportionate level of core costs and that CAFS remains vulnerable in terms of financial viability.

PHN and CAFS are now working on organizational areas that still need to be strengthened. Included in this is the development of a CAFS business plan that should help the organization market its services, project income and expenses, and further develop its service packages to meet customer needs. However, it is clear that OD assistance to CAFS should be terminated by 2007. After 2007, REDSO and Missions should be able to use CAFS services as needed to help accomplish their program objectives.

#### **The Regional Centre for Quality Health Care (RCQHC)**

The overall goal of RCQHC is "to develop the Centre's training and research capacity, and to contribute to its sustainability", as stated in its one of its publications "Building the Capacity of

the Regional Centre for Quality of Health Care, Makerere University to Train Consumers of Operations Research." In another document, the Centre's specific objectives were: 1) to develop the structure and content for courses for a one-year Diploma Course in Quality of Health Care; 2) to develop marketing materials and advertise the training courses region-wide; 3) to develop the capacity to prepare and disseminate high quality research and other reports; and 4) to increase Centre in-house research capacity

The Centre was a creation of REDSO, with its funding and technical direction managed by a REDSO funded CA. Only over the last four years, has the Centre become an independent entity under the Institute of Public Health, School of Medicine, at Makerere University. However, it is still very dependent on REDSO funding for its staffing, program expenses and most operating expenses (except for office facilities/furniture/utilities provided as an in-kind contribution of the University). The University has not as yet taken full ownership of the Centre, nor has the Centre's Advisory Board done so. It rarely meets and only has a mandate to provide technical guidance to the Centre. This financial dependence on REDSO and the virtual absence of an effective governance system for the Centre are the most important constraints to the Centre's institutional viability. As it stands now, the Centre is accountable mainly to REDSO, and this is not a healthy for either REDSO or the Centre. Some staff felt that REDSO exerted too much influence on staffing matters and technical direction. It is also inevitable that REDSO's funding of salaries and most program costs leads to dependency on the part of the Centre and excessive influence (and blame when things go wrong) on the part of REDSO. PHN and the Centre have commissioned the M&L Project to study this matter and develop recommendations by early 2006.

With respect to other institutional development tasks, the Centre has made progress, elaborating a Strategic Plan and annual work plans that guide operations. The Centre has also developed improved financial, personnel and related systems needed for it to function well as an organization. It is now aggressively marketing its training services (as reported by several USAIDs in the Region). One Mission recently sent its PHN officer and some counterparts to the Centre for short-term training.

### **The East, Central and Southern Africa Health Community (ECSAHC)**

In its 2002-2006 Strategic Plan, ECSAHC committed itself to the following: 1) Develop, recruit, and retain a high level of technical and support staff to ensure that CRHC can develop and implement innovative and strategic programs; 2) Strengthen management systems including finance, administration, human resources, monitoring and evaluation and reporting; 3) Enhance the capacity of the Secretariat and its governing bodies as well as the linkages between and among them to assure effective leadership of the community; 4) Develop well-structured corporate financial and resource mobilization plans; 5) Monitor and evaluate the efficiency and effectiveness of its own initiatives in the interest of continuous improvement; and 6) Develop and implement a marketing/communication strategy to improve the visibility of ECSAHC in the region

Points relevant to ECSA institutional viability include its strong governance/mandate to represent the region and provide relevant services to its member states; its proven ability to regenerate itself after hitting the depths in early 2000s; its funding of core costs, undertaking of business plan and trying to diversify its donor base, among others. REDSO's exit strategy is to

terminate core cost spending entirely, buy services in future and use the Secretariat as the principal conduit for setting PHN regional priorities/programs given its accepted role as representative for the Region.

### **NICRAs and Overhead Rates**

An important issue that was raised regarding the Partners' financial viability was their mechanisms for recovering core costs – those costs associated with basic maintenance and operations of an organization (i.e., administrative salaries, rent, utilities, supplies, etc.). The alternatives to directly financing core costs through contract line items are to establish either Negotiated Indirect Cost Rate Agreements (NICRAs) or flat overhead rates, both of which apply some set of percentages to directly incurred activity costs in order to recover the indirect core costs and both of which result in core costs being distributed proportionally across all contracts.

The three Partners are significantly different in nature and it was indicated that the issue of indirect cost rates is problematic for all three. As mentioned above, CAFS now has an approved NICRA with USAID. However they remain inconsistent applying indirect cost rates to their other clients such that core costs are still being covered disproportionately by REDSO.

Both RCQHC and ECSAHC are 'quasi-government' organizations and, as such, it is unclear how they are able to establish indirect costs with USAID. REDSO/PHN indicated that it is a question they have been asking, particularly with regard to ECSAHC, but have not yet been able to get a clear understanding of from REDSO support offices. The MTR team explored this issue to the limited extent possible under the scope of this assignment, but also did not receive a definitive answer as to what the options are for establishing indirect rates with such organizations.

### **CONCLUSIONS**

The OD process never really ends and organizations will inevitably advance and reverse themselves in one area or another over time. Concentrated REDSO assistance targeted at the OD of the Partners needs to end sooner rather than later, particularly when REDSO is also providing funds for core staff and operating costs. Such core support inevitably involves excessive donor influence and control, real or perceived by the Partners, that inhibits the organizational independence and self-direction of Partners.

M&L is handling the bulk of OD work with Partners, and equipping itself to service the Partners from its regional office in Nairobi. The Team sees this as a good match with OD needs and expects that this should reduce PHN management time on OD work.

There might be some advantages to linking monies spent on technical assistance (TA) with the networking process so that enhanced network development might lead to more use of East and Southern Africa-based consultants.

It is suggested that a study be made of the way in which the Institute of Child Health is an integral part of Makerere, apparently through the Institute of Public Health with which RCQHC has loose affiliation. This analysis should be included in the review of the Centre's governance to be undertaken shortly under the M&L Project.

The RCQHC is showing progress in putting into place most of the pieces targeted for OD improvement, and by the end of the strategy period it should have moved along about as fast as the other Partners in most aspects of the OD exercise. But, unlike the other Partners, the Centre will be greatly challenged to achieve an acceptable level of financial self-sufficiency by the end of 2007 given its current significant dependence on REDSO for core financial support. This makes it even more incumbent (than is the case with other Partners) upon the Centre and REDSO to agree upon a realistic exit strategy for the progressive withdrawal of REDSO funding for core expenses. Agreement should be reached soon and the withdrawal process begun in 2005.

PHN should consider not funding the Director in the next budget cycle. This seems feasible considering that the Centre reported \$70,000 earned in 2004 from course fees, a notable achievement. Why single out the Director's salary? In a small organization such as the Centre, the Director is responsible for managing programs, fund raising, public relations, marketing just about everything. Making his salary (and others) dependent on his initiative and skill provides a solid incentive for success. As important, his personal financial independence from REDSO should enhance his credibility among other collaborating organizations. For REDSO, relief from funding RCQHC staff reduces the likelihood of their being viewed (by counterparts) as "paymasters" rather than sources of technical assistance.

An important measure of viability is the ability to survive at some minimum level with income derived from fees for services, overhead charges or constituent dues. Lack of clarity expressed by some Partner staff suggests that REDSO needs a better defined exit strategy of progressively reducing funds for core costs. As discussed in Task 1 and further commented upon in Task 2, a new indicator should be introduced to measure progress towards this goal. Partner Business Plans scheduled to be prepared in the coming year will help in this process. It is also very important to resolve the issue of indirect cost rates to establish the best possible financial arrangement with each of the Partners.

A number of respondents expressed that there is not always total agreement on how particular funds should be spent once obligated to the Partners. While this lack of agreement is not inappropriate in and of itself, it is important to maintain a dialogue to collaboratively come to a consensus as much as possible.

## **PRIORITIZED RECOMMENDATIONS**

- 1) The Team recommends the REDSO conduct a special study on establishing indirect cost rates with the Partners in order to maximize their potential to recover core costs from a broader resource base and, thereby, increasing their financial viability.
- 2) The Team proposes that, with respect to the future use of the PIVA, REDSO consider the following options: (1) keep PIVA and drop all/most other existing IR 7.1 indicators since PIVA covers them all; (2) drop PIVA, create one or two Governance indicators and add these to the other IR 7.1 Indicators; and (3) simplify the PIVA and stay with the other indicators. The Team sees the last option the most advantageous given the energy/buy-in already expended in the PIVA process. PHN and Partners should attempt to further simplify the instrument by jointly identifying the 20 or so most important items in the current PIVA instrument that need to determine if progress is being made in institutional development. One approach would be to track the 20 or so indicators annually for the

next two years and the complete array of 116 indicators in 2007 at the end of the Strategy period. (See Annex F for further discussion on simplifying the PIVA.)

- 3) That Partners have relatively different mandates suggests the potential for them to work in concert, not in competition, to advance achievement of SO7. While the Partners positioned themselves at different organizational levels, the MOU indicates that they employ similar strategies (training, technical assistance, networking, and publications) to achieve their objectives. The Team recommends that REDSO continues to use the Partners' annual meeting to discuss and, if discussions are successful, develop with Partners a plan for some cooperative work perhaps organized around a specific, critical regional health issue.
- 4) To address the issue of staff turnover affecting Partners' viability, the Team recommends that the Business Plans being developed include a component that specifically addresses how to adequately maintain critical core functions at all times. Approaches to consider are possible overlap of skills amongst core staff, requiring a certain period of notice before resignation in employee contracts to allow some time for recruitment and training of replacement staff and scheduled periodic orientations (perhaps, every 6 months) for any new staff.
- 5) The Team proposes that REDSO conduct at least one annual workshop on USAID's funding processes. This would be particularly helpful in cases of staff turnover, either in the Partner institutions or at REDSO itself.
- 6) The team recommends that REDSO develop an approach to graduate Partner institutions to a level where REDSO is more a buyer of their health related services, possibly with elements of technical capacity building, rather than engaging in a full scale OD assistance effort. Clearly, core support to CAFS should end soon and in orderly fashion. It has already ended for ECSAHC with no REDSO/PHN funds going directly for operating costs.
- 7) PHN has rightly advised their Partners that REDSO cannot assure current funding levels from year to year, that the current strategy ends in 2007 and that what follows is yet to be determined. The Team proposes that that PHN start taking steps now to deal with the governance issue and, in particular, the Centre's financial dependence on REDSO. The M&L study on options for better university governance is a good start, but it will need to be combined with a clear idea of the program approaches that the Centre needs to pursue regionally (e.g. diploma level courses, TOT, short term customized courses, etc). The nature of University involvement in governance may very well have a bearing on the feasibility of different program approaches. Specifically, on funding, PHN should progressively reduce its share of core funding over the next three years, with the objective of funding no core costs by 2007, earlier if possible.

### **TASK 3: DETERMINE REDSO/PHN'S TECHNICAL EFFECTIVENESS IN THE AREAS OF MATERNAL AND CHILD HEALTH (MCH), NUTRITION, HEALTH CARE FINANCING, LOGISTICS AND DRUG MANAGEMENT, REPRODUCTIVE HEALTH (RH), HIV/AIDS, INFECTIOUS DISEASES (ID), AND ORGANIZATIONAL DEVELOPMENT**

*Aim: To establish to what extent SO7 activities are contributing to country, sub-regional, and regional health sector priorities in the above areas and how they have supported and complemented USAID's bilateral and Limited Presence Country (LPC) programs*

#### **FINDINGS**

##### ***Supporting and Complementing Bilateral Mission and LPC Programs***

Apart from a few exceptions, such as TB and TB/HIV technical assistance provided to TB priority missions, REDSO/PHN's direct services to missions and LPCs have little linkage and relationship to the SO7 Regional Program. Nor are they currently intended to. To the extent that health products and services developed regionally may apply to mission and LPC programs, so much the better. It is important to note that SO7 staff indicated that the aim of the Regional Program is to address issues either not taken on by individual country programs or by other donors and that have region-wide implications, or to accelerate and promote the adoption of health system improvements region-wide that have already been proven at country level under bilateral missions activities. While the latter often involves REDSO working with the same CAs that are accessed by the bilateral missions, there is still little collaboration directly with the missions themselves as these activities move to the regional level. This further distances the Regional Program from directly affecting country programs. Therefore, given this context, the discussion that follows will focus on how REDSO/PHN'S Regional Program (SO7) indirectly contributes to bilateral and LPC programs.

A REDSO staff member noted that REDSO works indirectly with country level programs via policy development that filters down to host countries and more directly through health training programs such as RCQHC's Quality of Care training in each one of the priority health areas. The Partners also impact Ministries and NGO's through the development (at a regional level) of guidelines and protocols that are later adopted by the Ministries. Similarly, as noted by another REDSO staffer, "Regional programs that succeed are those that are ahead of the curve, for example, the NHA guidelines, and that are eventually picked up and adopted by countries in the region." The Regional National Health Account Program was cited by several mission staff and various other key informants as a good example of what has worked well and made an impact at the country level.

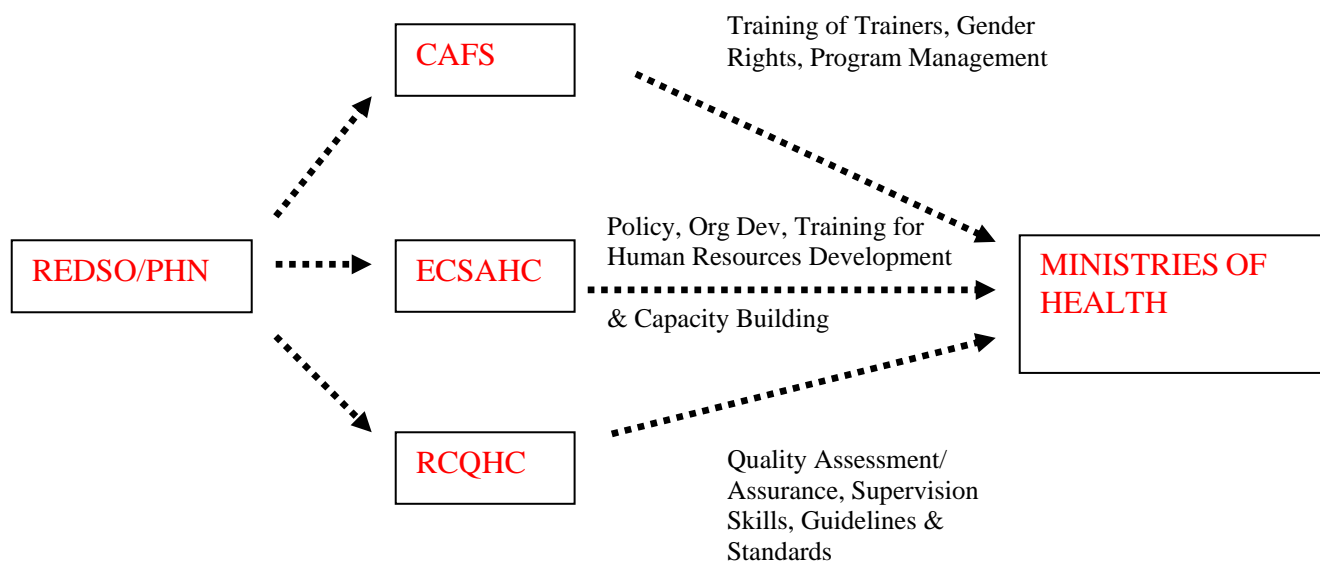
There is considerable sharing of critical information at regional and country level, promoted through regional initiatives such as meetings, workshops, and regional professional networks. There also are initiatives underway with the three Regional Partners (ECSAHC is about one step away from having the capability of running distance education programs, for example) to upgrade their IT and MIS capabilities. This will have a significant Region-wide impact on enhancing technical networks and facilitating links among donors, country health service institutions and regionally based resources such as the existing resource unit based at ECSAHC.

Lastly, while there is a loose pattern of engagement and very unclear relationships between the Regional Partners and the Bilateral Missions, several respondents from both groups indicated that some missions have a few times directly employed the services of the Partners, such as CAFS training programs, though, not necessarily aware of their relationship to REDSO. In fact, a respondent indicated that CAFS could benefit if there were more collaboration between REDSO and the bilaterals. This suggests that the institutional strengthening and capacity building that PHN is doing with the Partners stands to benefit the missions by making the Partners better equipped to offer their services.

Still, a majority of respondents felt that they did not have much to contribute in this area.

### ***Benefits to the Ministries of Health***

REDSO/PHN, through its Regional Partners, has been involved with the MOHs for close to a decade. The following diagram depicts how the Regional Partners relate to the Ministries.



According to one respondent, through ECSAHC programs funded by REDSO/PHN, the MOHs learn useful, cutting-edge information to improve performance. Through CAFS and the RCQHC, MOH professional staff develop skills by direct training. For example, Partners develop guidelines and protocols with the various MOHs. Results of REDSO/PHN-funded studies benefit MOHs in decision-making and MOH personnel are often direct beneficiaries of workshops and technical assistance. Partners directly contribute to health policy reform, the adoption of best practices and strengthening of network activities.

One respondent offered the following regarding REDSO/PHN-MOH collaboration:

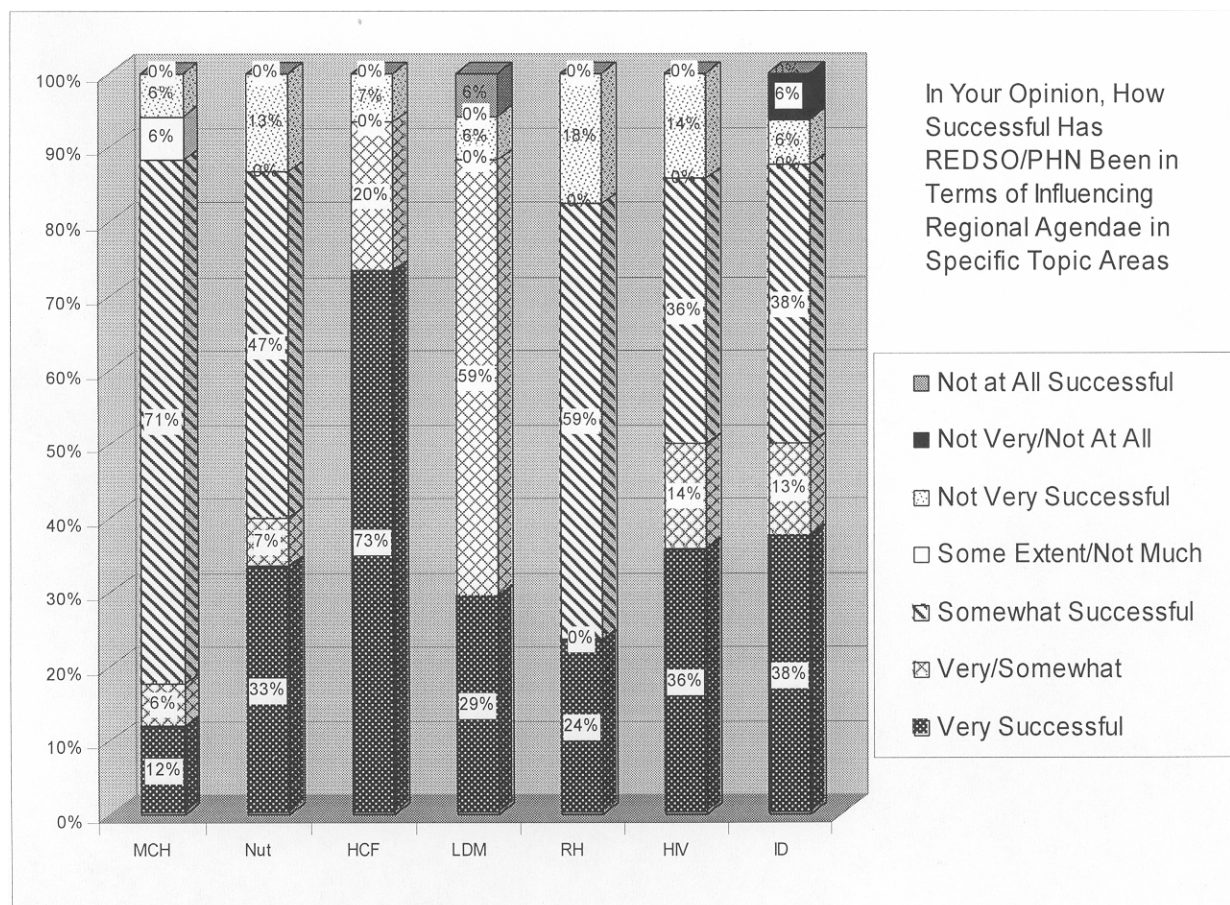
*REDSO is only one of dozens of funders supporting MOH activities. MOHs say they have benefited a lot from REDSO. Any help REDSO/PHN gives to regional organizations benefits ministries in last instance. Countries like Malawi, Kenya,*

*Zambia, Tanzania benefit from REDSO/PHN efforts through their participation in the Professional Networks REDSO/PHN has helped to strengthen.*

“Human capacity - here we have a problem”, reported yet another respondent. “Quality health care training is a current priority of PHN’s SO7 Program although workforce numbers may be the priority for MOHs. Top on the SO7 agenda should be both the training (quantity and quality) of MOH personnel and suggestions on how to increase the number of needed health workers in the field.”

### ***Moving Forward Regional Health Agendas***

The chart below shows that a majority of those with whom REDSO/PHN has worked closely feel that the Regional Program has been at least somewhat successful in moving forward regional agendas in all the topic areas, with HCF being sited as the most successful, and Logistics and Drug Management, Nutrition, ID and HIV/AIDS also being highly praised.

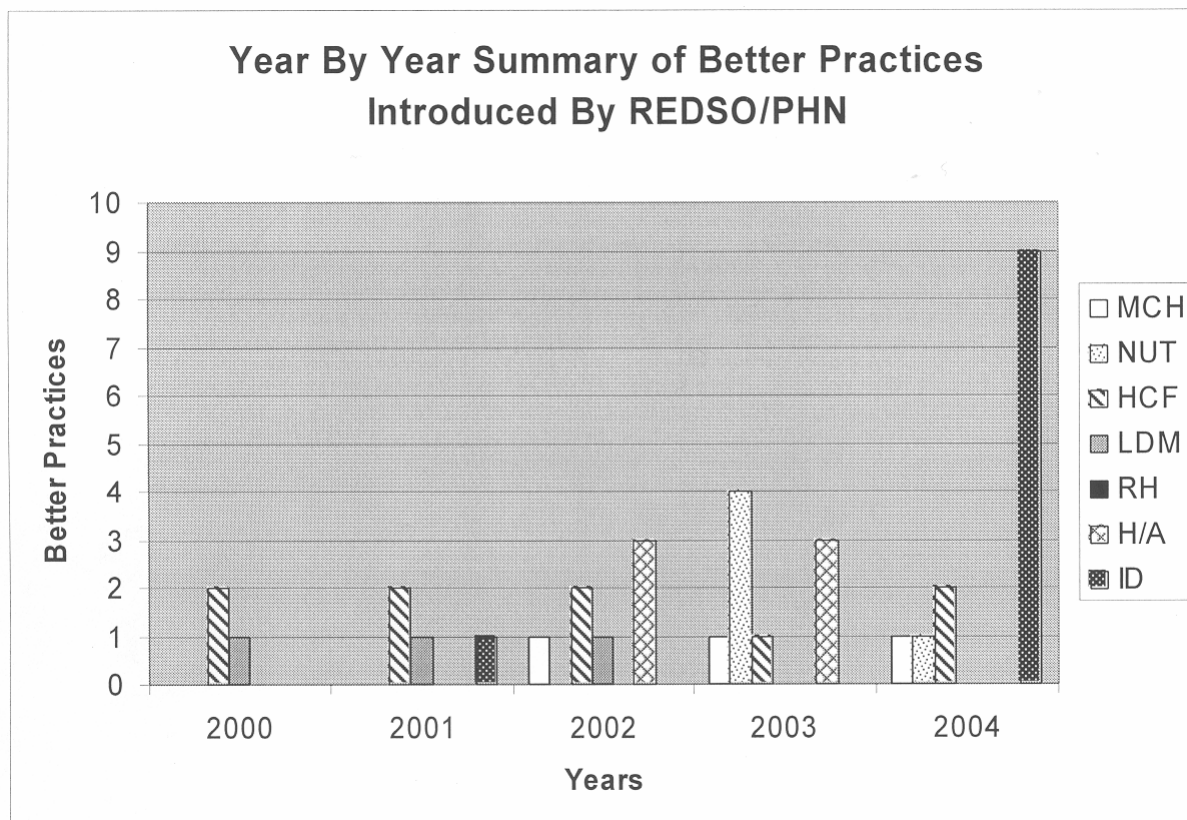


It was mentioned that issues associated with Logistics and Drug Management should be high on the list. Drug inventorying is a concern but there is little interest in some settings. Efforts to improve drug management often are constrained by countervailing forces such as corruption, an area outside the manageable interests of REDSO/PHN. It appears from the responses that REDSO/PHN has the reputation in the area with those with which it has worked to promote drug logistics and management.



### ***Evidence of Contributions of the Three Regional Partner Institutions***

As mentioned in Task 1, the Partners have been responsible for a steady increase in the numbers Better Practices (BPs) introduced/operationalized in the region. The chart below shows the Content Area of these Better Practices. Each BP is only counted in the year that it is introduced.



This chart shows that Health Care Financing (HCF) and Logistic and Drug Management BP's predominated at the start, and HCF has remained a steady focus throughout. HIV/AIDS appeared in 2002 and 2003, though, Nutrition BP's also came in high in 2003. A few Maternal & Child BP's have been introduced since in 2002, and Infectious Disease BP's dominated in 2004.

As has been described, each of the Partners plays a particular role to the SO7 Regional Program and each has made significant contributions particular contributions to the improving the policy environment and quality of service provision in the areas mentioned above. Annex H provides a more complete description of the Regional Partners' contributions with specific examples for each health topic.

NHA & Nutrition for PLWHA were again often cited by respondents as good examples of successful regional programs where standards, guidelines and policies are being promoted, human resources are being training and materials are being developed at country-levels so that in-country programs can tap into these resources.

Again, as shown in the chart above, 2004 saw a significant surge of ID Best Practices being introduced. SO7's Infectious Disease (ID) initiative primarily concentrates on two diseases –

malaria and TB, both of which respondents indicated have are areas in which Partners have had significant accomplishments. Currently the malaria control focus in REDSO/PHN is on prevention in pregnancy and the use of impregnated bed nets to reduce its impact.

MCH and RH have seen little activity to-date, although some successful contributions have been made, such as the RCQHC's Quality of Care Diploma, which has seen graduates go on to such pursuits as the development of standards for immunization of women and children in Uganda. Still, these are both areas in which the PHN office expressed interest in expanding in the future.

HIV/AIDS has been a focus of REDSO/PHN for a while but will become less so in the future, with the establishment of the REDSO HIV/AIDS Team and a new Strategic Objective (SO8) specifically for HIV/AIDS.

Regarding pre-service training programs, according to a number of key informants, there is a tremendous shortage in pharmacists, midwives, nurses, among others. There appears to be a need for short-term training programs, including Training of Trainers that can adapt to a local setting as opposed to setting up more academic types of programs.

In addition, as mentioned earlier, the Regional Program aims to direct its focus on those issues that keep it ahead of the curve. It was suggested by several respondents that possible areas to expand effort would be sexual/domestic violence, fistulas and female genital mutilation (FGM). These are issues reportedly not being picked up by many missions.

## **CONCLUSIONS**

The SO7 Regional Program is not substantively linked to PHN's support services to Missions and LPCs. Such services respond to the second two mandates of REDSO policy which cut across all REDSO offices. However there is solid evidence of linkage between SO7's Regional Partners/networks (and their products) with country level Ministries and other health service institutions. REDSO/PHN should study the implications of narrowing its availability to the Bilateral Missions to areas of focus in its SO7 to make better use of limited staffing and to allow for enhanced expertise in a fewer number of topic areas.

There is a case for more direct PHN linkages with Missions on SO7 matters to promote greater efficiency in the delivery of value added PHN services to missions and more synergy between mission and PHN efforts. One approach would be to have the Bilateral Missions do a 'buy-in' on REDSO/PHN Regional initiatives that have relevance for a specific country, particularly since the REDSO/PHN budget represents only 2.5% of PHN monies in the region. However there are time and staff constraints on both sides (Missions and Regional PHN staff) that make this synergy difficult to achieve. The Team discusses this further in Task 4 Section.

Possible areas for increased capacity building include working to close human resources training gaps. On the other hand, currently, there is lack of agreement as to whether or not health worker shortages are a result of lack of training resources, lack of funding of an adequate number of positions, or too many options for health workers to simply leave for opportunities in other countries. Gaining a handle on this issue should be a high priority for the region. REDSO/PHN should consider working with training institutes to accelerate and meet needs.

## **PRIORITIZED RECOMMENDATIONS**

- 1) As part of an improved monitoring and evaluation (M&E) component, the Team recommends that the Partners each dedicate twenty percent of a single staff person's time tasked to: a) identify indicators of program impact relevant to each specific activity; b) establish base-line data; and c) track and report on indicators to REDSO/PHN. As needed, the services of a relevant CA should be used to provide M&E technical assistance as Partners develop this capacity.
- 2) In order to get a better understanding of the ground-level impact of the Regional Program to-date, PHN should conduct a few focused studies on topics, such as NHA or Malaria and Pregnancy, that have seen a significant level of success. This would also serve to gain a better understanding why certain activities work and will help to direct future efforts.
- 3) In order to maximize the impact of REDSO/PHN on Bilateral Mission programs (for example, the development of new Human Resource guidelines), PHN should investigate how to have the Missions buy into the Regional Program in a way that addresses their specific agenda. Since the Partners deal with MOHs, that is the channel REDSO uses. This has the advantage of building possibly enduring relations between the Missions and the Regional Partners.
- 4) The Team recommends that PHN actively explore the options of focusing new efforts on such topics as sexual/domestic violence, fistulas and FGM – perhaps with the addition of new Partners with expertise in these areas as described in Task 4.

## **TASK 4: REDSO/PHN'S MANAGEMENT AND COORDINATION OF THE THREE DIFFERENT MANDATES**

*Aim: To establish REDSO/PHN's strengths and weaknesses in terms of SO7 management, coordination and communication of the three mandates*

### **FINDINGS**

#### ***Responding to the Three Mandates***

REDSO has three mandates: (1) to manage a regional program shaped by mission programs and GHAI principles, (2) to provide core and technical services to missions in the region, and to (3) to manage programs in countries where USAID has limited or no in-country presence. PHN must respond to all three. It manages its regional program according to the SO7 strategic framework and working primarily through its African Partner Institutions. The second two are REDSO-wide mandates and PHN currently contributes technical services directly to individual country missions and LPCs.

Management of the Regional Program requires considerable PHN attention. PHN extends technical and grant project management services to its three Regional Partners and coordinates these functions with approximately ten CAs and other regional agencies and networks focused on improving health services in the region. The Team estimates that PHN dedicates about 80% of its total staff time to implement its regional program, though this figure varies by individuals, as explained previously in Task 2 of this Report.

PHN services to Bilateral and LPCs are far less intensive, comprising about 20% of total staff time. These services are demand driven, provided only as requested by missions and REDSO's LPC Office, which now manages assistance to five countries. PHN's response to bilateral missions' requests for TA is based upon a yearly scheduling conference where PHN services are scheduled for each Mission throughout the year. Due to PHN responsibilities with respect to its other two mandates, it cannot easily handle last minute requests for assistance generated by missions.

PHN staff CVs are sent to Missions at the beginning of each year. Specific areas covered by the current staff are Maternal & Child Health (MCH), Health Care Financing (HCF), Logistics & Drug Management, Infectious Diseases (ID), Reproductive Health (RH), Nutrition and Organizational Development (OD). Two additional staff slots are currently in the process of being filled.

The MTR team queried the LPC Office regarding its use of PHN services and its satisfaction with them. One PHN staff person (currently the *TB and HIV/AIDS Advisor*) has the responsibility to liaise with the LPC Office and respond to their requests for services. When she is not able to provide the service, another PHN specialist might be able to do it. Otherwise, she helps the LPC Office secure the required services elsewhere. The LPC Office expressed a very high degree of satisfaction with this arrangement and with that the quality of PHN services.

The Team interviewed (by phone or visits) the key PHN staff person in seven missions (DR Congo, Rwanda, Malawi, Zimbabwe, Uganda, Tanzania and Kenya) regarding their views on PHN services, as well as, their opinion of REDSO/PHN's Regional Program.

With respect to the REDSO/PHN's direct support services, Missions gave high ratings to the technical competence of PHN staff demonstrated when services were actually rendered. However, missions rarely used PHN services in 2004, averaging about once per year per mission – a marked decline from the 1990s when REDSO/PHN staff provided considerably more mission support services. Some reasons which Missions (PHN Officers) gave for this decline in services include:

- Their perception that REDSO/PHN staff are too “busy” with other matters, unable to dedicate time needed for specific Mission requests and follow-up as needed.
- The feeling that REDSO/PHN staff skills are either covered by the bilateral's own PHN staff or are not relevant to their particular skill gaps.
- They no longer view PHN as a consistent source of assistance. They use other sources more frequently. They feel that there are better options such as the Global Bureau, CAs and contractors. Funding is not usually a constraint. These sources are easy to access and more likely to produce what is needed on time. Missions feel that they have more control over the output in these cases.
- There is no marketing of regional services to show how they might add value to mission and host country programs.

It should also be noted that in some cases missions have made a request at the beginning of the year but then missions changed or cancelled dates due to changes in circumstances.

Smaller and larger Missions did not differ significantly with respect to the above views. However, smaller missions did express a need for more information sharing among USAIDs regarding their programs. Some also would like REDSO to “know” their programs better, and advise them about resources for appropriate training and TA.

In regards to SO7's regional program, all Mission staff interviewed expressed little to no knowledge of PHN's Regional Program. They have only very limited knowledge of the three Regional Partner Institutions, and, when they have used these organizations, missions were unaware of any linkage to the Regional Program. One Mission sent an FSN and counterparts to RCQHC for training. In the same Mission, CAFS was a subcontractor under an important TA contract. Missions rated services rendered by these regional organizations as very good. Some noted that Regional Partners, particularly the RCQHC, are beginning to market their services.

The bilateral interviewees indicated that they were not involved or consulted in the design of SO7's regional program. Some were not interested at all in such involvement. But most said that they would have liked to participate in some way, but not in a manner that required them to meet or travel endlessly. Most said that they would like to know more about the regional program, preferably via visits, newsletters or other means.

The Team reviewed the REDSO System to track, quantify and obtain feedback on services rendered to Missions; particularly the STAR and the Annual Customer Survey. The Team feels that the information produced provides insufficient depth to be very useful in this assessment.

### ***PHN Staff Composition, Duties and Level of Effort***

Over last several years, PHN concentrated its attention on its regional program and, as noted previously, it spent less time on services to LPCs and missions. There are now seven professional staff positions, two of which are vacant but expected to be filled shortly. All current technical staff have at least one area of expertise, with varying degrees of experience (technical areas covered are indicated above). Three staff members have Activity Manager responsibilities – one manager for each Regional Partner – and also serve as Activity Managers for the services provided by CAs. All staff provide TA support the three Partners in their areas of expertise as needed. The TB & HIV/AIDS Senior Technical Advisor principally provides services to the LPCs and secondarily to missions. As mentioned earlier, all technical staff provide services in response to the requests of missions.

The Activity Manager roles are very time-consuming and complex, given all the requirements for grant management of the Partner organizations, the need to coordinate/guide inputs of CAs, the tracking/reporting demands of the PMP, and other administrative functions associated with Activity Management work in AID. They feel they have insufficient time to provide adequate TA to their Partner organizations and relevant regional networks, and almost no time to provide meaningful assistance to Missions. Some expressed that there is a continuing need for team-building, information sharing – also time to think creatively about resolving problems and shaping future assistance to regional needs. But, again, overload has worked against information sharing. Still, most PHN staff indicated that they are moving towards greater clarity in their roles and responsibilities under the current PHN leadership.

Another issue is that, while staff have the relevant range of technical skills, their preparation for the Activity Manager and OD roles has been less systematic. It has been more a case of learning by doing, instead of their receiving adequate formal training such as that completed by official CTOs, while many of the responsibilities are the same. The learn-as-you go method has implications on both efficiency and accuracy. While neither of these were explicitly raised as concerns, they can be implied to some extent from the concerns over workload. This suggests the desirability of short-term training or other means to upgrade skills in these areas. Given the demand for technical services to Partners and the possibility of expanding technical services to missions and LPCs, this might not be practical.

In addition to the current workload, the PHN Office has expressed an interest in expanding its Regional Program to include more Partners and networks, increasing the technical output of the Program and strengthening its capacity to add value to the country level programs of Ministries, NGOs and related institutions. The call for more Partners was echoed by a number of other respondents outside the PHN Office. The current emphasis on assisting only three organizations, all of whom need substantial OD assistance has its limitations. Despite their considerable achievements to date, these organizations still have a limited absorptive capacity to generate more output, particularly considering their needs in the OD area. One CA was recently asked by PHN to identify other possible partners, though no results were indicated as of yet. Unless another approach is taken, the addition of new Partners only stands to further increase the PHN staff workload.

### ***Country Prioritization***

The Team did not find any general rule or any specific instance calling for country prioritization by the REDSO/PHN staff. As support to bilateral missions and LPCs is based on specific requests, those tasks are scheduled first and then work related to the regional program takes up the rest the time.

### ***Coordination and Communications with Washington***

Based on discussions the assessment Team had in Washington, it appears that there is good communication between REDSO/PHN and Africa and Global Bureaus. Communication and program knowledge on both sides was frequently enhanced by well established professional relationships between REDSO/PHN and the Washington Bureaus. Some in the Africa Bureau suggested that yearly get-togethers (REDSO/ PHN and the relevant Washington Bureaus) to plan and program might lead to more funding or better use of funds.

### ***Coordinating with other Partners***

This was not a major topic of discussion during the assessment Team visits, but it appears that interaction with multilateral donors such as WHO, UNICEF, the World Bank, and others is modest. The new PHN Director said that this was case in a telephone conversation just prior to the Teams arrival in Nairobi. She did indicate, however, that she was already initiating more contacts with other donors. It is evident from the Team's observations in the field that Partners do coordinate/collaborate with an array of bilateral and multilateral donors as they pursue their program objectives.

## **CONCLUSIONS**

PHN staff spend most of their time on the SO7 Regional Program, managing Partner institutions and coordinating and monitoring the work of CAs. Missions know little about the Regional Program, and do not see it as relevant to their work. Missions only occasionally use PHN services. However, when rendered, missions rate PHN staff highly in terms of technical competency. Missions perceive PHN as too busy on other matters and not able to make meaningful and sustained contributions to their programs

The Team believes that the time now seems right to renew efforts and make a formal management commitment to promote more synergy between regional and bilateral efforts and seek greater efficiency in the implementation of REDSO's three mandates. Most of missions that the Team talked to felt that there was room for more collaboration, often citing technical areas such as the regional health care financing effort which added value to their bilateral programs. But their reference point was more often in the past, the Regional Program of five years ago. That being said, the Team does not suggest that any attempt be made to replicate past PHN efforts; today's dynamics are very different.

PHN staff, in terms of numbers and skills, are now meeting the basic requirements of their Regional Program (S07). With the addition of two staff (expected shortly) there should be more time available for Mission and LPC work. It is also feasible to absorb one or two new regional partners under the current PHN regime considering upcoming PHN staff additions, recent

adjustments to PHN staff responsibilities and new PHN leadership. New partners would have to be well-established institutions with donor experience and no requirements for OD type assistance. However, if the PHN office wants to expand its regional program using any more than a one or two new partners, it must find ways to reduce contracting and management duties associated with its Partner grants.

## **PRIORITIZED RECOMMENDATIONS**

The following are recommended scenarios for PHN's to explore in order to improve its management of the three mandates:

- 1) *Adjust the Current PHN Management Approach* – In addition to changes already underway in the PHN office, such as the filling of vacant positions and the presence of new leadership, the Team believes that the time now seems right to renew efforts and make a formal management commitment to promote more synergy between regional and bilateral efforts and seek greater efficiency in the implementation of REDSO's three mandates. Most of missions that the Team talked to felt that there was room for more collaboration, often citing technical areas such as the regional health care financing effort which added value to their bilateral programs. But their reference point was more often in the past, the Regional Program of five years ago. That being said, the Team does not suggest that any attempt be made to replicate past PHN efforts; today's dynamics are very different.
- 2) *Expand the Number of Regional Partners and Engage the Services of an Institutional Contractor (IC)* – This approach puts emphasis on removing the “bottleneck” effect caused by working exclusively through three partners. As OD work with the current Partners diminishes, an increase in technical activities will increase the potential impact of the SO7 Regional Program. In the case of a significant number of new partners, an IC could handle most grant management and contracting processes and, if necessary, selected TA or training functions. This would enable PHN staff to bring more technical expertise to bear on the regional program and on Mission/LDC requirements. More PHN staff time available for TA work should also provide opportunities to seek more synergy between regional work and services to missions.

For a more detailed discussion on these scenarios, please refer to Annex I.



## **GENERAL LESSONS LEARNED**

General lessons learned from this assessment are:

- Organizational Development (OD) is worthwhile but it needs to be simplified. The current tool to measure progress in institutional development involves 116 indicators. By its nature, OD requires a high level partner transparency and a donor/host country partner commitment to a lengthy process of examination and deliberate steps to achieve results. Institutional warts may be revealed and defensive positions taken leading to process shut-down. This is to be expected to some extent. But efforts should be made to simplify the process by reducing the watch list of indicators to be monitored and discussed, for example. Simplification is more likely to generate host country/donor understanding and buy-in to a meaningful OD process.
- Despite its complexity and need for simplification, most Partners found the PIVA exercise to be a useful approach to institutional development. However, another measure would increase its acceptability – to involve counterparts in a meaningful way to identify the best ways to measure institutional growth in the context of their organization and their culture. This is not to say the PIVA tool should be abandoned. Rather, the lesson here is that, when applying the PIVA in the future, it should be adapted to local circumstances in a collaborative manner at the onset, and subsequently as it may be revised or further adapted in the course of implementation, so as to achieve greater relevancy and buy-in to a process that is, under any circumstances, rough-going.
- Some technical contributions made by PHN through one or more of the Partner Institutions appear to have made a significant impact on policy formulation at regional and national levels, translating to favorable changes in health service delivery level at the local level. There appears to be a consensus among Partners and others (including many missions) that a good example of this is SO7 work in health care financing (HCF)/national health accounts (NHA).
- While there is some consensus the HCF/NHA work has been successful, there is not a consensus as to why this regional intervention seems to work, exactly how it originated, how it was diffused throughout regional/country systems, etc. The lesson here is two fold: 1) when something worked well, it is important to examine why so that this information can be used in future programming in the region and elsewhere, and 2) monitoring and evaluation is critical from the onset when initiating a promising intervention, so that lessons can be learned along the way. Neither appears to have been done in this case, at least in a systematic way that can be shared with a broader audience. But it is not too late. The HCA/NHA experience warrants a serious, in-depth case study to examine how it originated, what have been the results, how it was implemented, etc. Of particular interest to REDSO is how did this regional level initiative achieve synergy with the interests of Missions and their counterparts?

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## ANNEXES

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## **ANNEX A**

### **ASSESSMENT SCOPE OF WORK (SOW)**

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| <b>SCOPE OF WORK</b><br><b>MID-TERM ASSESSMENT OF REDSO'S STRATEGIC OBJECTIVE 7: ENHANCED<br/>REGIONAL CAPACITY TO IMPROVE HEALTH SYSTEMS</b> |
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#### **I. PURPOSE**

The purpose of this assessment is to provide the United States Agency for International Development's (USAID) Regional Economic Development Services Office for East and Southern Africa (REDSO/ESA) with an independent mid-term assessment of its Strategic Objective Seven (SO7) – Enhanced Regional Capacity to Improve Health Systems in East and Southern Africa.

REDSO/ESA is currently in the fourth year of implementing a seven-year mission strategy (2001-2007). The strategy was initially approved for a five-year period (2001-2005), that USAID/Washington subsequently extended for two additional years. As REDSO's PHN Office (REDSO/PHN) is approximately half way through implementing its strategy, it is commissioning this mid-term assessment to examine the progress of REDSO supported activities towards achieving the results outlined in the approved results framework and to make recommendations as to what activities should be continued, modified or enhanced so that the goals envisioned in the SO7 can be accomplished by FY 07.

In conducting the mid-term assessment, the selected team will

- 1) assess (managerially, technically and programmatically) the REDSO/PHN supported activities to date and their contributions towards achieving the stated SO7 results;
- 2) Recommend activities that need to be implemented, modified or enhanced, to reach the goals of SO7 by FY 07.

The assessment report is intended for internal REDSO/PHN planning purposes only. Sections of the report may be shared with outside sources at the discretion of USAID.

#### **II. BACKGROUND**

##### **REDSO'S STRATEGY**

REDSO traditionally focused on providing technical and analytical support services to twenty-two countries in ESA<sup>1</sup>, while implementing limited regional activities. Starting in the mid-1990's, REDSO's approach changed to providing a combination of investments and coordinated efforts in bilateral, regional, as well as central programs. While REDSO continued to provide services to bilateral missions, a regional program emerged that complemented mission efforts. This regional program emphasized strengthening African capacity to achieve food security and conflict management in the Greater Horn of Africa, and health and HIV/AIDS activities in all of

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<sup>1</sup> REDSO now covers 23 countries in the region.

ESA. REDSO's regional program was designed to closely conform to Greater Horn of Africa Initiative (GHAI)<sup>2</sup> principles, which underlie all REDSO assistance efforts throughout the ESA region. This is reflected in the three mandates pursued by REDSO *via* its current strategy:

- 1) manage a regional program shaped by mission programs and GHAI principles;
- 2) provide core and technical services to missions in the region;
- 3) manage programs in countries where USAID has limited or no in-country presence.

REDSO/ESA submitted its 2001-2005 mission strategy to USAID/Washington in the summer of 2000 and received approval for the strategy in September 2000. REDSO identified three SOs to achieve its goal of "A Healthy, Food Secure, and Peaceful Region":

SO5: Enhanced African Capacity to Achieve Regional Food Security

SO6: Enhanced Capacity for Managing Conflict in the Region

SO7: Enhanced Capacity to Improve Health Systems.

During REDSO's triennial review conducted in March 2004, USAID/Washington approved a two-year extension of the strategy through 2007 (completion date of September 30, 2008). In addition, USAID Washington approved a fourth SO (SO8): "Strengthened Programs for HIV/AIDS in the Region." This SO addresses HIV/AIDS through a multi-sectoral approach from a regional platform.

#### STRATEGIC OBJECTIVE SEVEN: ENHANCED REGIONAL CAPACITY TO IMPROVE HEALTH SYSTEMS

Since 1995, REDSO/PHN, which manages SO7, has been working to strengthen and support an existing, African-initiated, regional approach to addressing regional health issues. REDSO/PHN is strengthening the capacity of African organizations to play a lead role in addressing regional health priorities. This involves working with African partner institutions to refine and focus their regional strategies in order to increase their effectiveness. It also entails improving the African partner institutions' ability to receive and be accountable for increased funding. The initial REDSO/PHN strategy also entailed advancing partnerships and networks between and among African institutions and traditional US cooperating agencies (CAs) to work together to address regional health issues.

REDSO/PHN's approach involves enhancing the policy environment, expanding access to information, and assisting the exchange and adoption of systems, tools, and better technical practices throughout the ESA region using African networking as an integral strategy. Through its emphasis on partnerships with, and capacity building of, regional African organizations, REDSO's SO7 strategy was seen to directly contribute to the Africa Bureau vision of "a new Africa that is viewed as an equal partner by the global community; an Africa committed to developing strong market economies and to investing in health, education, training and infrastructure." By the end of the strategy period, it is envisioned that partners will be more

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<sup>2</sup> The Greater Horn of Africa Initiative (GHAI) was launched in 1994 to address the crisis and change experienced in the Greater Horn that have been triggered by regional, inter-related factors including population growth, land tenure issues, ethnic conflict, poor governance, environmental challenges, the availability of arms, and uneven terms of trade. GHAI has five underpinning principles: 1) African Ownership; 2) Strategic Coordination; 3) Linking Relief to Development; 4) Regional Perspective; and 5) Promoting Stability.

mature regional organizations, with clearly defined mandates and management and planning systems to support these mandates, and with financing strategies in place that will sustain regional networking activities after USAID funding ends.

The SO7 team shares with the rest of REDSO the three mandates of managing a regional program, providing technical services to missions in the region, and supporting programs in limited presence countries.

To achieve the first mandate of managing a regional program, the SO7 team works with three principal partners – the Commonwealth Regional Health Community Secretariat (CRHCS) in Arusha, Tanzania, the Center for African Family Studies (CAFS) in Nairobi, Kenya, and the Regional Centre for Quality of Health Care (RCQHC) at Makerere University in Kampala, Uganda. Descriptions of these African partner institutions are provided in Annex 2.

REDSO/PHN provides support to the region through these African partner institutions in four areas:

- 1) strengthening the institutional capacity and sustainability of regional partner institutions;
- 2) expanding the base of human, technical and program resources available to improve systems throughout the region;
- 3) increasing the analysis, dissemination, and application of information to enhance sector programs;
- 4) enhancing the policy environment by improving regional dialogue on regional policy issues in key technical areas that include HIV/AIDS, maternal and child health and nutrition, reproductive health, infectious disease, and health care financing.

These four areas of support correspond with the four Intermediate Results (IRs) REDSO identified to achieve SO7:

- IR 7.1 Improved Viability of Regional Partner Institutions
- IR 7.2 Broadened Technical Resource Base
- IR 7.3 Expanded Utilization of Critical Information, and
- IR 7.4 Expanded Policy Dialogue.

SO7's current results framework is attached in Annex 1. Technical briefs that summarize SO7's activities and achievements to date will be provided in the briefing packet.

### SO7 PERFORMANCE MONITORING PLAN

The REDSO strategy, approved in September 2000, included illustrative, interim indicators for the key results anticipated:

#### **SO7 Enhanced Regional Capacity to Improve Health Systems**

Number of regional strategies to address health systems implemented.

Number of selected better practices implemented regionally

Gender concerns incorporated into programs and policies of selected regional partners

#### **IR 7.1: Improved Viability of Regional Partner Institutions**

Percentage of partners' planned targets achieved

Leadership of partner institutions in regional strategy development (standards for measurement of the concept of 'leadership' will be defined later)

**IR 7.2: Broadened Technical Resource Base**

Number of activities using African consultants (disaggregated by African-led and non-African-led)

Number of cross-sectoral organizations and individuals participating in regional health activities

**IR 7.3: Expanded Availability of Critical Information**

Number of strategies within the region that include state-of-the-art (SOTA) knowledge or better practices

**IR 7.4: Policy Dialogue Promoted**

Number of policy working groups formed to address regional policy issues

Number of policy agendas developed by working groups

These illustrative indicators were reviewed and refined in consultation with partners over the course of several months. The revised set of indicators was further refined by SO7 US CA and African institutional partners during SO7's annual partners' meeting in April 2002. Since then, the PMP and indicators have undergone further revisions to clarify, streamline, and downsize the framework.

The following are the indicators the PHN Office currently is using to monitor SO7:

**SO7 Enhanced Regional Capacity to Improve Health Systems**

IR 7.1: Number of partner or network strategies meeting minimum standards

IR 7.2: Results of Institutional Leadership Survey

**IR 7.1 Improved Viability of Regional Partner Institutions**

IR 7.1.1: Institutional viability rating

IR 7.1.1.1: Human resource system developed and/or improved

IR 7.1.2.1: Detailed annual work plans are in place

IR 7.1.3.1: Number of organizations with a medium-term (five year) financial plan in place

**IR 7.2 Broadened Technical Resource Base**

IR 7.2.1: Number of people trained in technical skill areas according to a prescribed curriculum and learning objectives

IR 7.2.2: Consultant management system in place at partner institutions

IR 7.2.1.1: Number of networking activities with partners taking a key role

IR 7.2.2.1: Quality of training rating

IR 7.2.3.1: Number of cross-sectoral regional networking activities

**IR 7.3 Expanded Utilization of Critical Information**

IR 7.3.1: Number of times better practices are operationalized

IR 7.3.1.1: Number of events or activities exclusively focused on promoting better practices

**IR 7.4 Expanded Policy Dialogue.**

IR 7.4.1: Policy issues advocated for at the country level

IR 7.4.1.1: Number of country-level advocacy plans

IR 7.4.2.1: Number of policy issues critically analyzed at the regional level

The complete SO7 PMP will be provided in the briefing packet.

In addition, in 2001 REDSO/PHN developed the Partner Institutional Viability Assessment (PIVA), an organizational capacity assessment tool, to measure the three African partner institutions' capacity in key organizational development areas and to track their progress towards viability. The tool measures institutional capacity in the areas of governance, operations and management, human resources development, financial management, service delivery and external relations and advocacy. The tool was used to conduct baseline internal and external institutional viability assessments of the three African partner institutions and to provide them with recommendations for increasing their viability. It is intended to be used as a performance monitoring and management tool that partners and REDSO/PHN uses regularly to measure progress.

### **III. STATEMENT OF WORK**

The external assessment team will review SO7's technical, managerial, and programmatic strengths and weaknesses against the three mandates. Based on the assessment findings, the team will present results achieved to date, document lessons learned and, if necessary, make recommendations regarding new or modified approaches required to achieve the approved SO7 results in the remaining three years.

Illustrative questions to assist in the assessment are provided below. The assessment team is expected to refine this list of illustrative questions in its proposal to USAID. The assessment questions will be finalized with the SO7 team at the start of the assessment.

#### **TASK 1: Assess Progress to Date Towards Achieving SO7 Results**

Aim: To establish whether current REDSO/PHN supported and financed activities are the right ones to achieve the results outlined in the approved results framework

1. Review and document SO7's progress to date in relation to the strategic framework and the performance indicators (outlined in the framework and in the PMP). Determine and document key successes and constraints as well as expectations regarding future progress.
  - a) Are activities adequately supporting the relevant IRs and ultimately contributing to the achievement of the SO?
  - b) At the current pace and level of implementation, will the planned targets and results be achieved by the end of the strategy period?
  - c) Based on current experience and lessons learned, select an essential package of activities that should be continued, changed, or expanded in the remaining strategy period.
2. Determine if the results outlined in the SO7 strategic framework are within USAID's and REDSO/PHN's manageable interest.

TASK 2: Evaluate REDSO/PHN's Management Approach to Working with African Regional Institutions (CRHCS, CAFS, and RCQHC)

Aim: To establish whether REDSO/PHN's approach to working with African partner institutions is the most effective one for achieving the goal of improving health systems in the region or if modified or different approaches would be more effective.

1. Assess the effectiveness, cost efficiency, and applicability of the current way REDSO/PHN is working with African partner institutions (direct agreements and technical assistance through field support) towards achieving the goal of improving health systems in the region.
  - a). In light of the available funding, are there more cost efficient and effective approaches for achieving SO7 results  
(evaluate from both a short and long-term perspective)?
  - b). Are the three African partner institutions making progress towards institutional viability?
  - c). Do the three African partner institutions share REDSO/PHN's vision, goals, and priorities and are they committed to achieving them?
  - d). In these African partner institutions, is there African ownership of the process of regional exchange and adoption of better practices, technologies, and tools?
  - e). Has REDSO/PHN provided appropriate guidance and direction to contractors /recipients on how they support regional partners?
  - f). Is funding provided to African partner institutions and other partners on a timely basis and is it adequate for achieving desired targets?
2. Determine if the agreements (cooperative agreements and limited scope grant agreements) with the African partner institutions are adequate and appropriate instruments for achieving SO7 results. Are the African partner institutions complying with these agreements and is this being monitored by REDSO/PHN?
3. Determine if partner expectations are adequately managed.
  - Are their needs being regularly assessed?
  - Are partners involved in the performance management and assessment effort?
  - What opportunities do partners have to obtain information and to provide ongoing feedback to USAID on priorities and activity implementation?
4. Is the PIVA providing the African partner institutions with the best approach for management of institutional viability?
5. Review the roles and responsibilities of SO7 team members to determine if the current system of providing a combination of backstopping/CTO and technical area support is effective and efficient (versus, for instance, contracting out the financial oversight of the African partner institutions).



TASK 3: Determine REDSO/PHN's Technical Effectiveness in the Areas of Maternal and Child Health (MCH), Nutrition, Health Care Financing, Logistics, and Drug Management, Reproductive Health (RH), HIV/AIDS, Infectious Diseases (ID), and Organizational Development

Aim: To establish to what extent SO7 activities are contributing to country, sub-regional, and regional health sector priorities in the above areas and how they have supported and complemented USAID's bilateral and non-presence country programs

1. How does REDSO/PHN support and complement USAID's bilateral missions and non-presence country programs?
2. How has REDSO/PHN's technical program benefited the Ministries of Health in the region?
3. How successful has REDSO/PHN's regional program been in terms of moving forward the MCH, nutrition, health care financing, logistics, and drug management, RH, HIV/AIDS, and ID agendas in ESA?
4. Determine if the regional institutions that have partnered with REDSO/PHN demonstrate concrete (and documented) contributions to improving the policy environment and quality of service provision in the above areas.

TASK 4: Appraise REDSO/PHN's Management and Coordination of the Three Different Mandates of SO7 (Managing a Regional Program, Services to East and Southern African Missions, and Support to Limited Presence Countries)

Aim: To establish REDSO/PHN's strengths and weaknesses in terms of SO7 management, coordination and communication of the three mandates

1. Review the role and performance of the SO7 team to determine if the staff composition, duties, and level of effort are sufficient to comply with SO7's requirements and to achieve SO7 results.
  - a) Do team members have clear roles and responsibilities and adequate authority for implementing activities?
  - b) Is the team receiving adequate support from USAID support offices?
  - c) Is staffing of the team adequate? Does REDSO/PHN have adequate staff positions to manage the three mandates?
  - d) What is the impact of the development of the new SO8 (HIV/AIDS) on SO7's program? Are SO7 and SO8 collaborating effectively on joint activities?
  - e) Is SO7 collaborating effectively with other SO's, the limited presence counties team and Food for Peace?
  - f) Are any changes to roles or new team members needed?
2. How does the SO7 team prioritize work with different countries (for example, between non-presence countries and bilateral missions)?
3. Determine if the SO7 results framework has been the guide to achieving results?
  - a) Do the indicators reflect the true nature of the SO and will they permit the measurement of SO7's impact?

- b) Will the indicators permit USAID to attribute progress to its SO7 interventions? For instance, can the indicators accurately measure REDSO/PHN's impact on building the capacity of African partner institutions?
  - c) Have reasonable mechanisms been established for gathering the information/data needed to monitor progress and to evaluate impact and do these meet quality standards?
  - d) Are the established indicators being monitored regularly?
  - e) Have any evaluations been completed to fill performance information gaps? Is the information from prior evaluations informing decisions and action on relevant activities?
- 4. Determine, from the stakeholders' perspectives, if the SO7 team has been effective in responding to the three mandates of 1) managing a regional program, 2) providing technical services to missions in the region, and 3) managing programs in countries where USAID has limited or no in-country presence.
  - 5. Assess if coordination and communication between the REDSO/PHN staff and USAID/Washington (Global and Africa Bureau) has been effective and adequate (particularly with regard to explaining REDSO/PHN's capacity building work and reporting achievements, successes, and constraints)?
  - 6. Determine to what extent the SO7 team coordinates with other partners outside the three African partner institutions (such as other bilateral and multilateral donors, universities, NGOs and the private commercial sectors), especially in the areas of coordination and consultation.
  - 7. Based on current experience and lessons learned suggest, if needed, alternate management/administrative models and mechanisms for consideration in the remaining three years of strategy implementation.
  - 8. The agency is moving towards standardized indicators for health. If the list of indicators becomes available before this review, recommend the indicators that would best measure achievements under the current regional program. If it's not possible to use the new indicators to measure achievements of the current SO7 program, recommend how the results framework and PMP could be adjusted to respond to the new indicators.

#### **IV. SUGGESTED METHODOLOGY**

The assessment team is expected, in its proposal, to describe in detail a methodology for collecting the necessary information and data. The proposal should include a description of how the methodology responds to the above tasks and questions; from whom (and what), and how, data will be collected; and how the data will be analyzed. The methodology should be collaborative and participatory, including partners and key stakeholders (including USAID staff) as much as possible in planning and conducting the assessment.

The following essential elements should be included in the methodology as well as the additional methods proposed by the team.

SO7 Team Briefing: The assessment team will hold a preliminary meeting with the REDSO SO7 team in Nairobi, Kenya, agree on the key research questions, and finalize the schedule. Following this group meeting, the assessment team will likely conduct in-depth interviews with the members of the SO7 team individually.

Document Review: REDSO/PHN will provide the assessment team with a package of briefing materials related to the SO7 assessment. The team also is expected to collect and annotate additional documents and materials, which it will make available to REDSO/PHN for future use. The team will review all available materials prior to conducting key informant interviews and as necessary throughout the course of the assessment. A list of background documents that will be included in the briefing package is attached in Annex 3.

Key Informant Interviews: The assessment team will meet with key stakeholders and partners (a preliminary list of stakeholders and partners is attached in Annex 4, but the assessment team should add to this list as necessary) to conduct qualitative, in-depth interviews. The interviews should be loosely structured, but following a list of key discussion issues and questions as a guide. The interviewer should probe for information and takes notes as necessary. Whenever possible, the assessment team should conduct face-to-face interviews with informants. This will involve traveling to the three African partner institutions in Kenya, Uganda, and Tanzania. The assessment team also is expected to interview USAID Mission PHN staff in these three countries. In addition, the assessment team should seek qualitative information (for example, in the form of vignettes) that illustrates the impact of REDSO/PHN activities on individuals at the country and/or people level. When it is not possible to meet with stakeholders in person, telephone interviews should be conducted. The assessment team should also plan on one day to speak with USAID staff and other stakeholders in Washington.

## **V. DELIVERABLES**

Debriefing Meetings: The assessment team will hold two meetings to present the major findings and recommendations of the assessment. The meetings will be held prior to the team's departure.

1. The first debriefing will be for the SO7 team and will focus on SO7's accomplishments and the assessment team's recommendations regarding new or modified approaches required to achieve the approved SO7 results in the remaining three years of the strategy.
2. A second briefing, held in conjunction with the SO7 team, will be held for senior mission management and other mission staff as appropriate. This briefing will incorporate the insights gained in the first debrief.

Succinct briefing materials that are appropriate for each audience will be prepared and distributed during the briefings. Each meeting will be planned to include time for dialogue and feedback.

Draft Assessment: Prior to their departure, the assessment team will provide the SO7 team with a draft report that includes all the components of the final assessment report. Each of the six SO7 team members should receive a hard copy of the report and the team should also provide at least one electronic copy of the report in Word 2000 Format. USAID will provide comments on the draft report to the assessment team leader within 5 working days of receiving the report. The contractor is then required to submit a final report within 8 working days after USAID provides its feedback on the draft report. The final report is to be submitted to the REDSO/PHN both in hard copy (6 copies) *via* express mail and in electronic form. The assessment report must include, at

minimum, the following: scope and methodology used; important findings (empirical facts collected by evaluators); conclusions (evaluators' interpretations and *judgments* based on the findings); recommendations (proposed actions for management based on the conclusions); and lessons learned (implications for future designs and for others to incorporate into similar programs). *A proposed report outline is attached in Annex 5.*

### **Final Assessment**

The final report must address the comments provided by USAUD/REDSO regarding the draft.

## **VII. TEAM COMPOSITION**

In the proposal, a three-member assessment team should be proposed. The team should have the following

### Health Analyst (Team Leader)

Must have at least MA degree and training in medicine, public health or a social sciences field related to health. Extensive experience applying health Analyst in program and project design or evaluations in developing countries.

### Budget/Financial Analyst

Must have at least MA degree and training in management, economics, or public administration with specific emphasis on public finance, project, and program financial Analyst in developing countries. Extensive experience analyzing the institutional structure of firms and organizations, and budget and financial analyses of project design and project evaluations.

### Institutional Analyst

At least MA degree and academic training in social science or management field with emphasis on social and economic research methods, including quantitative measurement of an organization's performance. Extensive practical experience analyzing developing country institutions and developing measures to improve their performance.

In addition, the team leader must have excellent English language skills (both written and verbal) as s/he will have the overall responsibility for the final report. The proposed team leader is expected to provide a sample of a report s/he has written for consideration by USAID.

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## ANNEX B

### DOCUMENTS AND WEBSITES REVIEWED

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- 1) REDSO/ESA Strategic Plan 2001-2005: Strengthening Partnerships and Capacity. Sanitized Version December, 2000
- 2) Strategic Objective Seven: Enhanced Regional Capacity To Improve Health Systems
- 3) REDSO Population, Health and Nutrition Office Performance Monitoring Plan SO7: Enhanced Regional capacity to Improve Health Systems
- 4) Cooperative Agreement 623-A-00-02-00107-00 between REDSO/ESA and the Centre for African Family Studies (CAFS). September 2002.
- 5) Limited Scope Grant Agreement between USAID and the Commonwealth Regional Health Community Secretariat for East, Central, and Southern Africa (CRHCS) for the Partnership for Health Networks. USAID Activity Numbers: 698-0483.23 and 621-1001
  - Amendment Number 4: September 19, 2001
  - Amendment Number 5: September 9, 2002
  - Amendment Number 6: September 15, 2003
- 6) Limited Scope Grant Agreement between USAID and the Regional Centre for Quality of Health Care (RCQHC), Makerere University, Institute Of Public Health for the Partnership Program For Health Networks
  - Amendment Number Three, August 29, 2003
- 7) Improving Institutional Viability of Regional Health Partner Institutions; Final Report of Regional Partner Institutional Viability Assessment (PIVAS) of Three Key Regional African Partner Organizations. Carolyn M. Jefferson , Management and Organizational Development Advisor, September 28,2001
- 8) Presentation: REDSO Triennial Review, Strategic Objective Seven: Enhanced Regional Capacity To Improve Health Systems. March 24, 2004,
- 9) Presentation: Andrew Sisson, REDSO Director, Briefing: REDSO/ESA/PHN, Strategic Objective 7: Enhanced Regional Capacity to Improve Health Systems. January 24
- 10) Partner Institutional Viability Assessments (PIVAs) for the three African partner institutions for 2002 and 2003
- 11) Background Paper on Regional Approaches, Keith Brown
- 12) Doing Business Differently, Ray Kirkland
- 13) SO7 Technical Briefs

- 14) SO7 Annual & Financial Reports
- 15) Partner Quarterly Reports
- 16) DRAFT Meeting Report: USAID/REDSO Population, Health, and Nutrition Office Partners' Meeting – October 2004
- 17) Report of the REDSO/ESA SO7 Partners Meeting – April 2002
- 18) Memorandum of Understanding between CAFS, CRHCS-ECSA, and RCQHC
- 19) A Comparative Analysis between CAFS', RCQHC's and CRHCS' Leadership Effectiveness in the Region, Management & Leadership Program, Management Sciences for Health, December 2003
- 20) A Review of Financial and Programme Management for the Commonwealth Regional Health Community Secretariat for East, Central and Southern Africa, Management Sciences for Health, December 2001
- 21) Report of the Task Force on CRHC Institutional Reforms, Commonwealth Regional Health Community for East, Central and Southern Africa, August 2002
- 22) Building the Capacity of the Regional Center for Quality of Health Care, Makerere University to Train Consumers of Operations Research, RCQHC/FRONTIERS, May 2004
- 23) Review of RCQHC's Potential Research Role, Population Council, January 2004
- 24) Centre for African Family Studies (CAFS): [www.cafs.org](http://www.cafs.org)
- 25) Regional Center for Quality of Health Care (RCQHC): [www.rcqhc.org](http://www.rcqhc.org)
- 26) Commonwealth Regional Health Community Secretariat (CRHCS): [www.crhcs.or.tz](http://www.crhcs.or.tz)
- 27) African Malaria Vaccine Testing Network [www.amvtn.org](http://www.amvtn.org)
- 28) USAID/REDSO/ESA: <http://www.usaidredso.org>
- 29) USAID/Kenya: <http://www.usaidkenya.org/>
- 30) USAID: <http://www.usaid.gov>
- 31) U.S. Embassy, Nairobi: <http://usembassy.state.gov/nairobi/>
- 32) U.S. State Department: <http://www.state.gov/>
- 33) Regional Economic Development Services Office for East and Southern Africa (REDSO/ESA): <http://usaid.gov/pubs/cbj2003/afr/redso>
- 34) Institutionalization of National Health Accounts in ECSA: Progress Report: [http://www.phrplus.org/Presentations/NHA/Bura\\_Institutionalisation.ppt](http://www.phrplus.org/Presentations/NHA/Bura_Institutionalisation.ppt)

- 35) Report of the 40<sup>th</sup> Regional Health Ministers' Conference 1- 5 November 2004, Victoria Falls, Zimbabwe:  
<http://www.crhcs.or.tz/modules.php?op=modload&name=UpDownload&file=index&req=getit&lid=77>
- 36) East Central and Southern African Health Community (Ecsa) Djcc Programme: 27-30 July 2004. Arusha, Tanzania:  
<http://www.futuresgroup.com/Documents/AfricaPRSPWkshopSum.pdf>
- 37) Support for Analysis and Research in Africa II (SARA II) Annual Report Project Year 1 (FY00): [http://www.dec.org/pdf\\_docs/PDABZ666.pdf](http://www.dec.org/pdf_docs/PDABZ666.pdf)
- 38) Technical Report No. 21 - Health Reform Policy Issues in Malawi: A Rapid Assessment *July 1998 Prepared by:* Gil Cripps USAID, REDSO/ESA Dan Kress, Ph.D. Abt Associates, Inc. Clifford Olson, M.A. Abt Associates, Inc. Consultant Alex Ross USAID, Bureau for Africa:  
<http://www.phrplus.org/Pubs/te21fin.pdf>
- 39) Policy Project – REDSO ESA:  
<http://www.policyproject.com/countries.cfm?country=REDSO/ESA - 18k>
- 40) Regional Health Systems Improvements:  
<http://www.usaid.gov/policy/budget/cbj2005/afr/pdf/623-007.pdf>
- 41) The MIPESA Newsletter: [http://www.cdc.gov/malaria/pdf/MIPESA\\_Newsletter.pdf](http://www.cdc.gov/malaria/pdf/MIPESA_Newsletter.pdf)
- 42) Final report on a workshop to develop proposals for collaborative TB and HIV/AIDS programme activities Nairobi, Kenya 11 - 15 February 2002:  
[http://w3.whosea.org/en/Section10/Section186/Section1805\\_7775.htm](http://w3.whosea.org/en/Section10/Section186/Section1805_7775.htm)
- 43) Remarks of Dr. Steven Shongwe, Regional Secretary, Commonwealth Regional Health Community, Arusha, Tanzania, December 10, 2003:  
<http://www.msh.org/seam/conference/presentations/Agenda/AgendaDay1/transcripts/1-Shongwe.pdf>
- 44) Meeting Report , 29 March to 1 April 1998, Nairobi, Kenya, Prevention and Control of Cervical Cancer in the East and Southern Africa Region: [http://www.path.org/programs/p-wom/p-w-cxca/cxca\\_add\\_work.htm - 9k](http://www.path.org/programs/p-wom/p-w-cxca/cxca_add_work.htm - 9k)
- 45) Towards CAFS Sustainability: <http://www.cafs.org/confrep2.pdf>
- 46) RCQHC - Overcoming Barriers to Effective Maternal Anemia Interventions during Antenatal Services in Uganda: [http://www.mostproject.org/IVACG/Overcoming\\_Barriers.pdf](http://www.mostproject.org/IVACG/Overcoming_Barriers.pdf)
- 47) Draft Agenda – PHN SOTA Africa Meeting Windsor Golf & Country Club Nairobi, Kenya June 10 – 15, 2002: [http://www.phnsota.com/afr/agendafiles/SOTA\\_Agenda5-291.pdf](http://www.phnsota.com/afr/agendafiles/SOTA_Agenda5-291.pdf)
- 48) Annex 3 List of Participants – East Central and Southern African Health Community (ECSA) 40<sup>TH</sup> Regional Health Ministers' Conference and Commemoration of the 30<sup>th</sup> Anniversary of the ECSA Health Community 1-5 November 2004:

- <http://www.crhcs.or.tz/modules.php?op=modload&name=UpDownload&file=index&req=getit&lid=77>
- 49) USAID/RWANDA Integrated Strategic Plan 2004-2009 Volume 3: HIV/AIDS Strategy: <http://www.eldis.org/static/DOC14465.htm>
- 50) The Performance Management Toolkit - A Guide to Developing and Implementing Performance Management Plans: <http://www.lastfirst.net/catalog.php?cPath=876&sort=4&page=3> - 43k
- 51) Recommendations for Performance Monitoring and Impact Assessment for USAID/Kenya Subsector Development Programs: <http://www.wiram.de/downloads/CaseStudies/Subsector.doc>
- 52) USAID/Zambia – Private Sector Development Results Package – 7 February 2000: <http://www.usaid.gov/zm/Docs/revps.doc>
- 53) Completing the PMP: [http://www.usaid.gov/am/assets/06\\_-\\_Completing\\_PMP\\_\(ArmeniaPartners2004\).pdf](http://www.usaid.gov/am/assets/06_-_Completing_PMP_(ArmeniaPartners2004).pdf)
- 54) Strengthening Monitoring & Evaluation of Maternal Health Programs: <http://www.cpc.unc.edu/measure/publications/pdf/bu-04-07.pdf>
- 55) African Union/International Bureau for Animal Resources (AU/IBAR): <http://www.africa-union.org/>
- 56) Association for Strengthening Agricultural Research in East and Central Africa (ASARECA): <http://www.asareca.org>
- 57) Common Market for Eastern and Southern Africa (COMESA): [www.comesa.int](http://www.comesa.int)
- 58) Intergovernmental Authority on Development (IGAD): [www.igad.org](http://www.igad.org)



## ANNEX C

### PERSONS CONTACTED

| Last Name      | First Name | Position                                    | Organization    | Location      |
|----------------|------------|---|-----------------|---------------|
| Amirthanayagam | Vathani    | PHN Team Leader                             | USAID/REDSO/ESA | Nairobi       |
| Anderson       | Cheryl     | Deputy Director                             | USAID/REDSO/ESA | Nairobi       |
| Ashley         | Jeffrey    | Director Regional HIV/AIDS                  | USAID/REDSO/ESA | Nairobi       |
| Ayoti          | Everlyne   | Program Assistant                           | USAID/REDSO/ESA | Nairobi       |
| Barry          | Maura      | Somalia Program Manager                     | USAID/REDSO/ESA | Nairobi       |
| Cripps         | Gilbert    | Sr. Tech. Advisor, Health Care Financing    | USAID/REDSO/ESA | Nairobi       |
| Davis          | Connie     | Sr. Tech. Advisor, TB & HIV/AIDS            | USAID/REDSO/ESA | Nairobi       |
| Ervess         | Shirley    | Regional Program Impact Advisor             | USAID/REDSO/ESA | Nairobi       |
| Fuller         | Flynn      | Director REDSO/LPC                          | USAID/REDSO/ESA | Nairobi       |
| Grubel         | Alix       | Regional Organizational Development Advisor | USAID/REDSO/ESA | Nairobi       |
| Hardy          | Nancy      | Supvy Program Officer/Office Chief          | USAID/REDSO/ESA | Nairobi       |
| Hunter         | Mark       | Controller, RFMC                            | USAID/REDSO/ESA | Nairobi       |
| Jandy          | Margaret   | Secretary/Administrative Assistant          | USAID/REDSO/ESA | Nairobi       |
| Jefferson      | Carolyn    | Organizational Development Advisor          | USAID/REDSO/ESA | Nairobi       |
| Kieffer        | Mary Pat   | HIV/AIDS Coordinator                        | USAID/REDSO/ESA | Nairobi       |
| Masbayi        | Victor     | Child Survival & Nutrition Specialist       | USAID/REDSO/ESA | Nairobi       |
| Mukira         | Loise      | Program Development Specialist              | USAID/REDSO/ESA | Nairobi       |
| Ndinya         | William    | Acquisition Specialist                      | USAID/REDSO/ESA | Nairobi       |
| Nyaga          | Rose       | Financial Analyst                           | USAID/REDSO/ESA | Nairobi       |
| Sisson         | Andrew     | Regional Director                           | USAID/REDSO/ESA | Nairobi       |
|                |            |   |                 |               |
| Augustine      | Randolph   | Intern                                      | USAID/AFR       | Wash, DC      |
| Clark          | John Paul  | AFR/SD Rep                                  | USAID/AFR       | Wash, DC      |
| Harvey         | Mary       | AFR/SD Rep                                  | USAID/AFR       | Wash, DC      |
| Mehdi          | Subhi      | AFR/SD Rep                                  | USAID/AFR       | Wash, DC      |
| Sukin-Klauber  | Hope       | AFR/SD Rep                                  | USAID/AFR       | Wash, DC      |
| Husain         | Ishrat     | AFR/SD Rep                                  | USAID/GH        | Wash, DC      |
| Mengech        | Patricia   | GH/RCS Rep                                  | USAID/GH        | Wash, DC      |
| Pressman       | Willa      | GH/RCS Rep                                  | USAID/GH        | Wash, DC      |
| Ruebush        | Trent      | U.S. NAMRID and CDC                         | USAID/GH        | Wash, DC      |
| Stanton        | Mary Ellen | Maternal Health Advisor                     | USAID/GH        | Wash, DC      |
| Wallace        | Julia      | GH/RCS Rep                                  | USAID/GH        | Wash, DC      |
|                |            |   |                 |               |
| Connolly       | Caroline   | PHN Officer                                 | USAID/Rwanda    | Kigali        |
| Cunnane        | Robert     | PHN Officer                                 | USAID/Uganda    | Kampala       |
| Dunlop         | John       | PHN Officer                                 | USAID/Tanzania  | Dar es Salaam |
| Halpert        | Peter      | PHN Officer                                 | USAID/Zimbabwe  | Harare        |
| Jessop         | Suzanne    | Acting PHN Chief                            | USAID/DR Congo  | Kinshasa      |
| Kirkland       | Ray        | Regional Director USAID/Budapest            | USAID/Budapest  | Budapest      |
| Nyirongo       | Mexon      | PHN Officer                                 | USAID/Malawi    | Lilongwe      |
| Paz-Castillo   | Janet      | PHN Officer                                 | USAID/Kenya     | Nairobi       |
|                |            |   |                 |               |
| Ilinigumugabo  | Alois      | Head of Technical Department                | CAFS            | Nairobi       |
| McWest         | Christiane | Senior Liaison Officer                      | CAFS            | Nairobi       |
| Muka           | Jacqui     | Director                                    | CAFS            | Nairobi       |
| Thambu         | Palmer     | Accountant                                  | CAFS            | Nairobi       |
|                |            |   |                 |               |
| Malizi         | Levi       | Accountant                                  | RCQHC           | Kampala       |
| Mutungi        | Alice      | RH and Maternal & Neonatal Health Advisor   | RCQHC           | Kampala       |
| Naikoba        | Sarah      | Child Health & Nutrition Advisor            | RCQHC           | Kampala       |
| Ojuka          | Kennedy    | Administrator                               | RCQHC           | Kampala       |
| Okullo         | Joel       | Director                                    | RCQHC           | Kampala       |
| Putu           | Chilunga   | Infectious Disease Advisor                  | RCQHC           | Kampala       |
| Tindyebe       | Dennis     | HIV/AIDS Advisor                            | RCQHC           | Kampala       |

| <b>Last Name</b> | <b>First Name</b> | <b>Position</b>                              | <b>Organization</b> | <b>Location</b> |
|------------------|-------------------|--|---------------------|-----------------|
|                  |                   |  |                     |                 |
| Bura             | Mark              | Coordinator, Health Systems                  | ECSAHC              | Arusha          |
| Chebet           | Kenneth           | Coordinator, HIV/AIDS                        | ECSAHC              | Arusha          |
| Msolaji          | Adam              | Information, Doc. and Comm. Officer          | ECSAHC              | Arusha          |
| Mujanja          | Sarah             | Coordinator, HR & Capacity Building          | ECSAHC              | Arusha          |
| Ngwenya          | Zoonadi           | Administrative Secretary                     | ECSAHC              | Arusha          |
| Watiti           | James             | Information Officer                          | ECSAHC              | Arusha          |
|                  |                   |  |                     |                 |
| Birungi          | Harriet           | Researcher/Programme Associate               | Pop Council         | Nairobi         |
| Grum             | Ida               | Senior Program Officer                       | M&L                 | Nairobi         |
| Kilele           | Phoepe            | East and Central Africa Regional Coordinator | CORE I              | Nairobi         |
| Kirika           | Roselind          | Co-Coordinator, Senior Program Associate     | RLI                 | Nairobi         |
| Lynam            | Pamela            | Regional Director                            | JHPIEGO             | Nairobi         |
| Magwa            | Ndugu             | Reg Director – FP & RH Program ESA           | FHI                 | Nairobi         |
| Sserunjogi       | Louise            | Activity Director                            | MOST/ICH            | Kampala         |
| Thuo             | Michael           | Regional Technical Advisor                   | RPM+                | Nairobi         |
| Wanjama          | Leah              | Senior Policy Advisor                        | Policy II           | Nairobi         |
|                  |                   |  |                     |                 |

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## ANNEX D

### PARTNER PROFILES

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#### **THE CENTRE FOR AFRICAN FAMILY STUDIES (CAFS)**

Headquartered in Nairobi, with a regional office located in Lome, Togo, CAFS is an African regional institution that provides training, technical assistance and research services to sub-Saharan organizations providing reproductive and family health services.

Founded by the International Planned Parenthood Federation (IPPF) in 1975, CAFS is now an autonomous international non-governmental organization with a governing board composed of international experts in the field of reproductive health and population.

USAID today is the leading external donor, but other funding is provided by IPPF, the World Bank, and the Packard and Rockefeller Foundations, as well as from fee income from courses and technical consultations. CAFS has sound leadership, a qualified but lean technical staff, and a gradually expanding client base. It must be noted, however, that CAFS' clients, principally African NGOs and government ministries, typically are on modest or meager budgets and seldom are able to pay the kind of prices that would move the organization swiftly toward financial self-sufficiency.

In addition to teaching courses in advocacy, community empowerment, and consultant skills, CAFS has had many years of experience offering short courses in population communications, clinical training of trainers, management of reproductive health programs, and research and evaluation. Through its technical consulting services, CAFS focuses on institutional capacity building and on enhancing collaboration and building alliances among reproductive and family health organizations. To respond to sector needs, CAFS' activities are increasingly focusing on HIV/AIDS and Child Survival and health sector reform. In sum, CAFS fills a multi-faceted need in the region and is a valuable partner in the sector. In particular, CAFS will work with USAID to enhance capacity-building, training, and networking in the NGO sector.

REDSO/PHN supports CAFS in continuing to expand the scope of its operations from its earlier focus on family planning to taking a wider role in promoting improved reproductive health, including HIV/AIDS prevention and care, in the region. This includes establishing improved information systems that promote greater use of African expertise, including the development of a consultants' database; expanding the range of courses; and taking a broader leadership role in bringing together African NGOs working in reproductive health. REDSO/PHN also continues to provide a level of core support to CAFS to support continued strengthening of CAFS' organizational and technical capacity.

## **EAST, CENTRAL & SOUTHERN AFRICA HEALTH COMMUNITY (ECSAHC)**

ECSAHC (formerly, the Commonwealth Regional Health Community Secretariat, or CRHCS) is an intergovernmental, policy-making body, formed in 1974 to foster and strengthen regional cooperation and capacity to address the health needs of commonwealth countries of East, central, and southern Africa. It achieves this by advancing health policy dialogue, regional cooperation, and political will to support quality health services.

ECSAHC is directly administered by member state governments. Currently 14 member countries comprise the Secretariat: Botswana, Kenya, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe.

Ministers of Health of member governments constitute the Conference of Health Ministers, the highest regional governing body in the East, central, and southern African health community. These Ministers meet annually to review national health activities and to elaborate regional priorities. At a meeting of the Conference of Health Ministers in 2002, it was agreed that the membership of CRHCS should be expanded to include non-commonwealth countries in the region. The name “East, Central and Southern Africa Health Community” (ECSAHC) was chosen to better reflect the organization’s new configuration, and is often used in tandem with CRHCS.

The Secretariat, located in Arusha, Tanzania, is mandated with operationalizing the regional agenda and implementing regional health initiatives identified by the Conference of Ministers. It accomplishes this by facilitating information dissemination, supporting policy dialogue and advocacy, and improving collaboration and networking among member states. ECSAHC also manages several technical programs that support member states in addressing regional health challenges in a collective and strategic manner. These are: Family and Reproductive Health, Food Security and Nutrition, HIV/AIDS, Health Systems Development, Human Resources Development and Capacity Building, and Information Communication and Dissemination. These technical programs each are supported and monitored by a Program Steering/Expert Committee.

The Secretariat’s Board of Management, the Advisory Committee, is comprised of Health Permanent Secretaries from the member states. The Director’s Joint Consultative Committee, which is composed of Permanent Secretaries, Deans of Medical Schools, and Directors of Health Services and Research Institutions, meets annually to discuss collaboration in health services, training, research, and other technical areas.

CRHCS recognized early on that achieving its goals requires building the technical and managerial capacity of the Secretariat. During a consultative process, ECSAHC identified specific institutional and technical needs including:

- strengthening the technical and management capacity of the advisory, executive and leadership committees;
- expanding the public and private sector support of the institutional development plan;
- improving technical assistance and support to member states and stakeholders;
- integrating a strategic approach into the regional health policy program support; and
- broadening the scope of strategic partnerships.

REDSO/PHN has responded to these requirements and works with ECSAHC to strengthen tools and systems for monitoring and evaluating regional health policy, expand partnerships and networking, and improve implementation of ECSAHC’s strategic and institutional development plans.

## **THE REGIONAL CENTRE FOR QUALITY OF HEALTH CARE (RCQHC)**

The RCQHC is the youngest of REDSO/PHN's three major partners, but is firmly lodged in one of the region's oldest and most prestigious institutions: Makerere University in Kampala, Uganda. Located within the Institute of Public Health in Makerere's Faculty of Medicine, the RCQHC's vision is to become a center of excellence advancing the quality of health care in Africa.

The RCQHC was officially recognized in August of 1999. But the initial impetus for the Centre's establishment came from the Regional Quality of Health Care Network, a group of over 1000 health care professionals from 18 nations, working in ministries of health, NGOs, and the private sector in ESA. This network, originally managed out of REDSO, was institutionalized at Makerere University to ensure its long-term survival.

Makerere University, through the RCQHC, offers a Graduate Diploma course in quality of health care with the aim of training a critical mass of health care providers and managers in the public and private sectors in the region. In addition, a series of short courses are offered throughout ESA in the Centre's technical focus areas of reproductive health, maternal and child health and infectious diseases and its process areas of guidelines and standards, training, logistics, supervision, quality assurance and cost containment.

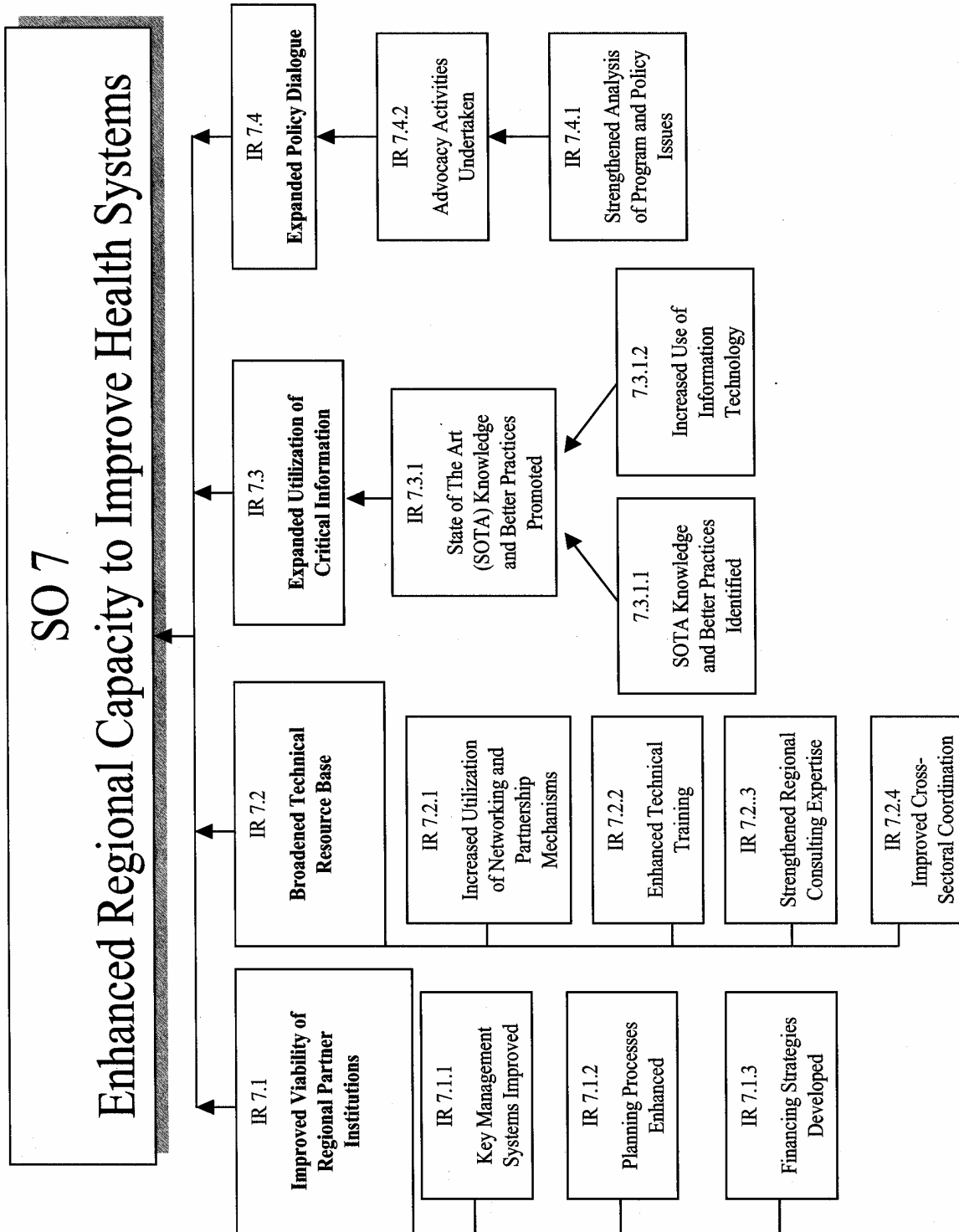
The RCQHC employs technical advisors who lead these education and training activities but also promote the technical and process focus areas through networking; technical assistance to governments; documentation and dissemination of better practices; and intervention-linked research.

While the Regional Centre is already undertaking many activities, the organization is still nascent and requires support in a number of areas in order to function at its full capacity. REDSO/PHN supports the recruitment and capacity building of staff and the strengthening of the financial, administrative and management systems of the Regional Centre. In turn, the Centre, through support from REDSO/PHN, enhances the capacity of health systems in the region through education and training and other activities.

The commitment of energy, dedication, and resources from the university and increasingly from other donors augurs strongly in favor of the RCQHC and places it in an ideal position to facilitate improvements to the quality of health care in the region.

# ANNEX E

## SO7 RESULTS FRAMEWORK



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## ANNEX F

### TOWARDS A SIMPLIFIED PIVA

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Partners should be involved in the process of simplifying the PIVA tool to be used in 2005 and 2006. This should help ensure Partner “buy in” and more relevance to the circumstances and problems associated with achieving more institutional viability in the ECSA regional context. A one/two day workshop hosted by REDSO and facilitated by M&L might be the way to start the process in early 2005.

The Team suggests that two to four indicators be selected/perhaps modified from those found in each of the six PIVA components (i.e. Governance System; Operations/Management System; HRD System; Financial Management System; Program and Service Delivery System; and External Relations and Advocacy System). All Partners need not have the same indicators. There should be room for differences among institutions according to where they sit in PIVA’s continuum of Start-up to Mature organizations.

When selecting indicators, it is important to link the establishment of systems indicators with outputs. For example:

- ▶ Most Partners now have Strategic Plans and Annual Work Plans. What is more important now is the extent to which they are used. What percentage of anticipated outputs were achieved? Were they the highest priority ones? Are plans reviewed/revised periodically? Are they linked to personnel performance evaluations, etc?
- ▶ All Partners have an established governance system; some are not functioning well (RCQHC) and others appear strong (ECSAHC). Do governing Boards hold themselves and their organization’s staff accountable for achieving the targets established in agreed upon Plans? What corrective measures, if any, are taken when performance lags? Do Board members they meet and perform other functions required of them in the constitution of the organization?

The Team believes that all of the six PIVA components are important. However, some may be more important than others. Partners surely would have some insights in this regard. The Team would rank Governance, Financial Systems and Program/Service Delivery as the most important components of institutional viability. Strong governance encourages accountability, the achievement of performance standards and resource mobilization, making it difficult for an organization to fade away. Good financial systems help to sustain the funding support from donors and from an organization’s constituency, so important for NGOs. And quality services and products delivered on time and meeting real needs are important measures of an organization’s success and its viability. Very important for institutional viability is the extent to which an organization has reached a basic level of financial self-sufficiency. The team deals with this issue elsewhere in the report, but it is worth emphasizing again.

Whatever the approach that PHN takes to simplify the PIVA, it is important that it be done in a collaborative manner with its Partners. This will help ensure its relevancy in the remaining years of the strategy period and should enhance Partner commitment to the process.

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## ANNEX G

### BEST PRACTICES

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#### FY 2000

1. **Production of National Health Accounts in the context of health systems and health system performance measurement:** In countries in the ECSA region, health care is provided by a complex and changing mix of government and private sector entities (both for profit and non-profit). In such an environment, policy makers need reliable information on the sources and uses of funds for health, preferably comparable across countries, in order to enhance health system performance. National Health Accounts (NHA) helps to provide that information.
2. **Logistics Management Information Systems** (district level systems) – including inventory control and drug order processing:
3. **Hospital Costing** (department level costing):

#### FY 2001

4. **Business planning and budgeting models** – in support of hospital autonomy
5. **Costing of essential health services** – district level and below
6. **Drug quantification** (for essential package – including morbidity based estimates
7. **Improving human capacity** – including improved workforce planning and deployment practices

#### FY 2002

8. **Performance improvement approach (PIA) to improve quality of interventions -** Performance Improvement approach encourages organizations to discover the root causes of obstacles that stand in the way of providers achieving their potential. The process is a sustainable effort that builds capacity within the organization to recognize and address problems. Wide-ranging factors affecting performance are analyzed and prioritized because not all factors can or should be addressed simultaneously. **Source:** [http://www.prime2.org/prime2/pdf/PI\\_300.pdf](http://www.prime2.org/prime2/pdf/PI_300.pdf)
9. **NHA sub-analysis – Classification of health expenditure by disease condition:** Many of the countries in the region are facing increasing pressure to meet a growing burden of disease – this situation has been exacerbated by the additional demands placed on the health care delivery system by HIV/AIDS and other priority diseases such as TB and Malaria. Classifying expenditures according to health or disease condition can be an extremely useful way to analyse the allocation of resources among specific types of health conditions, and such a scheme can help to illuminate important parts of the overall health system – the approach is therefore exceptionally helpful for displaying results to policy makers who are interested in how well the health system is doing in specific areas of concern such as HIV/AIDS.
10. **GOALS Model for estimating the effects of resource allocation decisions on the achievement of targets of national HIV/AIDS strategic plans:** The GOALS model is intended to support strategic planning at the national level by providing a financial modeling tool to link program targets/goals with funding. It is designed to assist planners in understanding the effects of funding



levels and allocation of these resources on program impact. In most national HIV/AIDS strategic plans, activities are not tied to specific reduction in prevalence targets that countries want to achieve. The GOALS model helps to explain how different resource allocation patterns across interventions can lead to reductions in HIV incidence and prevalence, and also how improved coverage can be achieved for treatment, care and support programs.

## **FY 2000**

**1. National Health Accounts:** In countries in the ECSA region, health care is provided by a complex and changing mix of government and private sector entities (both for profit and non-profit). In such an environment, policy makers need reliable information on the sources and uses of funds for health, preferably comparable across countries, in order to enhance health system performance. National Health Accounts (NHA) helps to provide that information.

**2. Logistics Management Information Systems** (district level systems) – including inventory control and drug order processing: Push based supplies systems often using drug kits are gradually giving way to demand driven pull systems and indent ordering for specific drugs and medical supplies. This requires more sophisticated systems for inventory control and increasingly the use of computerized business systems that provide procurement and order information as well performance monitoring and reporting.

**3. Hospital Costing** (departmental costing): hospital efficiency is an important element in the management of overall health resources because they are the largest and most costly operational units of the health systems in the ESA region and account for a large proportion of the health sector's financial, human and capital resources. Hospitals typically utilize nearly half of total national health expenditures and up to 80% of government recurrent health sector budgets. They also use a large proportion of the most highly trained health personnel. Cost information is needed to ensure that existing resources are used more effectively through improved allocation patterns and increased efficiency in the management of hospital operations. Cost information is also needed to set prices for services and to determine revenue objectives.

## **FY 2001**

**4. Business planning and budgeting models** – in support of hospital autonomy. Public sector hospitals have come under scrutiny due to their bureaucratic complexity, their low standards of care, the heavy burden they place on public funds and the perceived difficulties in ensuring their efficient and effective functioning under centralized government control. One policy option that has been put forward to improve performance particularly for the large referral hospitals is the granting of greater autonomy in running their operations. However substantial investments are required in capacity building before hospitals can become effectively autonomous. Key areas include organization structure, general and financial management as well as human resources management and management information systems. To tie these components together and make effective use of cost information there is need to integrate the revenue and expenditure budgets under one coherent long term business plan for the hospitals to ensure viability and financial sustainability.

**5. Costing of essential health services** – at district level and below. Many countries in the region have adopted the concept of an Essential Health Package (EHP) in order to clearly define a package of key interventions to reduce the burden of avoidable mortality and disease, particularly among the poorest members of society. The EHP focuses on conditions affecting women during pregnancy and delivery, and children under five. To effectively deliver on these commitments there is need to cost the proposed EHPs and channel resources to carefully selected services to greater effect, to improve equity in access to health

services and to set priorities. The costing process will use methods such as the WHO Mother-Baby Package as well as improved systems for drug quantification and costing.

**6. Drug quantification** (for essential health packages – including morbidity based estimates). Accurate quantification of drug requirements is needed to optimize drug budgets based on priority health problems to be treated, and to implement the most cost-effective treatment approaches. Many of the critical issues in quantification can be more effectively handled using computerized methods and the RPM Quantimed system is an example of database software that makes the process much easier. This offers three major advantages – speed, accuracy and flexibility. In addition once the basic data and assumptions are programmed into the software, calculations can be done automatically. This means that once a computerized drug list and quantification model have been developed, they can be used and re-used repeatedly for any number of Districts.

**7. Infection Prevention & Control:** Infection prevention practices are crucial to the safety of health workers, individuals obtaining health care, and the communities in which they live. Even with limited staff, equipment, and funds, health care facilities in the developing world can fight deadly diseases such as HIV infection and hepatitis B by following some simple, cost-effective procedures. Elements include: hand washing, gloving, aseptic technique, surgical scrub and surgical attire, use and disposal of needles and other sharps, instrument processing (including decontamination, cleaning, sterilization and high-level disinfection, and storage), housekeeping and waste disposal.  
<http://www.engenderhealth.org/res/onc/about/about-ip.html>

**8. Workforce Planning & Deployment** – Professional Regulatory Frameworks: Using a handbook on developing professional regulatory frameworks (PRF) and the successful prototype PRF that was developed by the East, Central and Southern Africa College of Nursing (ECSACON), countries are in the process of developing their country specific PRF documents. The frameworks address the scopes of practice for nursing and midwifery, practice standards, competencies and the core content and standards for education. Four countries have so far developed their own documents – Botswana, Lesotho, Uganda and Zambia. A draft ECSACON Code of Ethics has also now been finalized and will accompany the PRFs.

**9. Workforce Education and Training** - promotion of harmonization and standards in education and practice. The East, Central and Southern Africa College of Nursing (ECSACON) and the College of Surgeons for East, Central and Southern Africa (COSECSA) are both successful colleges without walls whose overall aim is to promote professional excellence and improve health services available in the region. The College of Surgeons was established following the ECSACON model and is now formally registered in Malawi, Kenya, Uganda, Zambia and Eritrea and further countries plan to become members in the future. Hospital accreditation has been completed for over 50 hospitals in eight countries. Further accreditation visits are planned to expand the program in the region. Discussions have now taken place with Dentists in the region who may join as a faculty of the College and also Ophthalmologists who may form their own College under a Regional Postgraduate College of Medicine. Other specialties are also considering forming regional colleges along the lines of ECSACON.

## **FY 2002**

**10. Performance improvement approach (PIA).** Performance Improvement approach encourages organizations to discover the root causes of obstacles that stand in the way of providers achieving their potential. The process is a sustainable effort that builds capacity within the organization to recognize and address problems. Wide-ranging factors affecting performance are analyzed and prioritized because not all factors can or should be addressed simultaneously. **Source:**  
[http://www.prime2.org/prime2/pdf/PI\\_300.pdf](http://www.prime2.org/prime2/pdf/PI_300.pdf)

**11. NHA sub-analysis – (by disease):** Many of the countries in the region are facing increasing pressure to meet a growing burden of disease – this situation has been exacerbated by the additional demands placed on the health care delivery system by HIV/AIDS and other priority diseases such as TB and Malaria. Classifying expenditures according to health or disease condition can be an extremely useful way to analyse the allocation of resources among specific types of health conditions, and such a scheme can help to illuminate important parts of the overall health system – the approach is therefore exceptionally helpful for displaying results to policy makers who are interested in how well the health system is doing in specific areas of concern such as HIV/AIDS.

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**13. Performance assessment for logistics and drug management:** The REDSO Regional Logistics Initiative identified a need for a rapid indicator-based performance assessment tool aimed at providing policymakers and program managers with current information to assess overall system performance and make decisions on drug policy and logistics/drug management issues. Sources of material used in developing and implementing the tool included the WHO guide on “How to investigate drug use in health facilities, (selected drug use indicators)”, 1993; field tested tools such as the RPM “Rapid Pharmaceutical Management Assessment”, 1995; the WHO “Indicators for Monitoring National Drug Policies, A Practical Manual”, 1999; and the JSI “Logistics Assessment Tool – LSAT”, 2001.

The resulting assessment design focuses on both regional and country issues such as the identification of barriers to harmonization of drug registration, standard treatment guidelines and the Essential Medicines List. The assessment further measures availability, accessibility, affordability and acceptability of quality essential drugs and medical supplies. The tool can therefore be used systematically for monitoring the implementation of national drug policies and the performance of the national supply chain components, and can serve to diagnose problems, point to root causes of system failures and suggest solutions for how problems can be addressed. It can also be used to assess the impact of interventions as well as evaluating the effectiveness of interventions designed to improve performance at different levels of the system.

**14. Community Health Fund:** Research and analysis of several community-based health financing schemes in ESA in 1999 led to the development of the REDSO/PHR “Guide to Designing and Managing Community-based Health Financing (CBHF) Schemes in East and Southern Africa”, Oct 2000. The guide covers all the basic building blocks for successful CBHF from design to implementation through monitoring and evaluation of scheme performance. As a result of work with the CHF network in ESA and specifically with the Community Health Fund in Tanzania, there was a need to develop and field test systems for improved administration, operational control and financial management of schemes managed at District level. Tried and tested systems are now available for recording payment information for patients, recording and reconciliation of fees collected, depositing funds, maintaining financial ledgers and overall record keeping and reconciliation of accounts including computer data processing at District level.

**15. Voluntary Counseling and Testing:** VCT provides the opportunity for people to know their HIV status with quality counseling support to help them cope with a positive or a negative test result. The majority of adult populations are HIV negative, even in high HIV prevalence settings. Knowing one is

HIV negative can serve as a strong motivating factor to remain negative, particularly for those who may otherwise assume it is too late to adopt safer sexual practices. For people who test positive, while VCT services can link them to options for treatment if and where they exist, and to care and support, just as important, it allows for adoption of preventive measures. For some, self-protection is a stronger motivator for safer sex than the need to protect others; for others, the responsibility to avoid spreading the virus is itself the critical motivator. Both contribute to HIV prevention. Knowing one is HIV positive also provides an opportunity to protect sexual partners and to plan for the future from an informed position - deciding on marriage and on child bearing, and preparing children and family for the progression of disease and death. Source: <http://www.fhi.org/en/HIVAIDS/pub/fact/vctmodels.htm>

**16. Faith Based Organizations involvement in Prevention, Care and Support:** (tool): With the advent of the HIV/AIDS epidemic, civil society has been intimately involved in the prevention, care and support of infected and affected people. Faith based organizations found themselves in the position to provide care and support but some lacked the skills needed to mobilize the community and work in the HIV/AIDS arena. A tool was developed that would assist faith based organizations more readily plan and implement HIV/AIDS prevention, care and support activities in the rapidly changing face of the HIV epidemic. Source: <http://www.fhi.org/en/HIVAIDS/pub/index.htm>

**17. Post Abortion Care:** Morbidity and mortality due to unsafe abortion continue to pose a serious global threat to women's health and lives. It is estimated that worldwide, every year, almost 20 million unsafe abortions take place and 80,000 women die from complications following unsafe abortion. Access to contraceptive methods to prevent unwanted pregnancy and a continuum of postabortion care that includes comprehensive counseling, access to contraception and family planning to prevent future unwanted pregnancies or to practice birth spacing, and access to reproductive and other health services, are all essential means of preventing unsafe abortion and improving the lives of women and their families. The five essential elements of PAC are: Community and service provider partnerships for prevention (of unwanted pregnancies and unsafe abortion), mobilization of resources (to help women receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs; counseling to identify and respond to women's emotional and physical health needs and other concerns; treatment of incomplete and unsafe abortion and complications that are potentially life-threatening; Contraceptive and family planning services to help women prevent an unwanted pregnancy or practice birth spacing; and reproductive and other health services that are preferably provided on-site or via referrals to other accessible facilities in providers' networks. Source: [http://www.ipas.org/english/womens\\_health/postabortion\\_care/model.asp](http://www.ipas.org/english/womens_health/postabortion_care/model.asp)

## FY 2003

**18. Guidelines for iron/folate supplementation:** Compliance with iron/folate dosage has been poor in the region due to bad taste and side effects which get worse with daily dosage intake. Recent studies have recommended varying dosages for various levels of anemia prevalence. These recommendations can help improve compliance given that the dosage is less and has potential for creating same impact on anemia as the dosages that were previously being used. Although this has been in the literature for sometime the knowledge has not been available to health workers who are providing ANC services in the region. The better practice is a simplified tool that provides information about correct dosage of iron and folate to health workers at the ANC clinic. Nutritional anemia was defined in a 1968 WHO technical report as “a condition in which the hemoglobin content of the blood is lower than normal as a result of a deficiency of one or more essential nutrients, regardless of the cause of such deficiency.” To determine which nutritional deficiencies were most responsible, WHO coordinated a series of studies in pregnant women in which anemia, serum folate, transferrin saturation and serum B-12 were assessed. They concluded that “Iron deficiency was present in 40–99% of the pregnant women studied and was undoubtedly responsible for the major proportion of anemia” (WHO 1968).....The singular importance of iron deficiency was restated with more confidence by Baker and DeMaeyer (1979): “The major factor responsible [for

nutritional anemia] is a deficiency of iron, with folate deficiency also playing a role in some population groups, especially in pregnant women.” **Source:** [www.emedicine.com/med/topic1188.htm](http://www.emedicine.com/med/topic1188.htm)

**19. Promotion of Indigenous Food:** Many of the indigenous African food crops and useful plants are endangered and some species face extinction. The disappearance of indigenous food crops and useful plants clearly represents a threat to food security for rural households. It is important to stem the erosion of plant genetic resources to conserve biodiversity and increase utilization of Africa's indigenous food crops and useful plants. [http://www.inra.unu.edu/programme\\_area2.htm](http://www.inra.unu.edu/programme_area2.htm)

**20. Nutritional Care of People Living with HIV/AIDS** - Nutrition plays a critical role in comprehensive care and support for people living with HIV/AIDS. Nutritional interventions can help manage symptoms, promote response to medical treatment, slow progression of the disease, and increase the quality of life by improving daily functioning. To strengthen capacity to implement nutritional care and support in eastern and southern Africa, stakeholders in the region identified the need to improve incorporation of nutrition and HIV/AIDS into pre-service training for doctors, nutritionists, and other health care workers in the region. To meet this need, the Regional Centre for Quality of Health Care (RCQHC) in Uganda, FANTA, the LINKAGES Project, and the SARA Project, developed *Nutrition and HIV/AIDS: A Training Manual* in consultation with instructors from several educational institutions in the region. This pre-service training manual is part of a series of activities that RCQHC, FANTA, LINKAGES, and SARA are implementing with other regional partners to strengthen nutritional care and support capacity. **Source:** [www.thebody.com/dietnut.html](http://www.thebody.com/dietnut.html)

**21. Workplace HIV programs:** The large number of adults infected with HIV and those dying from associated diseases in Africa, calls for all organizations - private businesses, non governmental organizations and government departments - to address the pandemic in the workplace. Addressing the effects and impacts of HIV/AIDS is critical in ensuring the smooth running of an organization's activities and maximizing investment in human resource development. Organizations of all sizes are faced with the challenge of having to manage employees infected or affected by HIV/AIDS. The sensitivities and complexities of HIV/AIDS can pose a special challenge to management and staff of all organizations. Promoting workplace HIV programs empowers managers from both the private and public sector to establish and maintain HIV/AIDS workplace interventions including policies, prevention activities and care and support services at both managerial and operational levels. **Source:** [http://www.cafs.org/courses\\_2004.html](http://www.cafs.org/courses_2004.html)

**22. ARV Therapy:** ARV therapy prolongs life, decreases or eliminates symptoms of AIDS, improves quality of life and delays disease progression. ARV therapy can also reduce the rate of transmission of the disease. **Source:** <http://www.aidsconsortium.org.uk/publicationspages/baggaley.htm>

**23. Care of HIV-infected children:** UNAIDS estimated that there were 2.6 million children <15 living with HIV in sub-Saharan Africa (SSA) at the end of 2001. These huge numbers of HIV-infected children, some of whom are now reaching adolescence, put an increased burden on health systems, communities and families. Studies have shown that as many as 30% of HIV-infected children die before 1 year of age in sub-Saharan Africa, but it is also known that many of these deaths can be prevented through proper nutrition, early diagnosis, proper prophylaxis and medical care for opportunistic infections, and use of antiretroviral drugs. Much has been learned about caring for HIV-infected children, but this knowledge has not been incorporated into standards of care in the African region. **Source:** Triennial 04 ANNECCA.doc

**24. Standards for immunization:** In 1999, the World Health Organization (WHO) Department of Vaccines and Biologicals launched the Immunization Safety Priority Project to boost its activities in this

area, with the aim of establishing a comprehensive system to ensure the safety of all immunizations given in national immunization programs..... There are four areas of focus in the project: quality control and assessment tools to ensure vaccine safety from clinical trials up to and including the point of use; research and development of safer and simpler delivery systems; access to safer and more efficient systems for vaccine delivery and sharps waste management; and mechanisms to respond promptly and effectively to vaccine safety concerns. The project emphasizes the importance of advocating safety and developing necessary infrastructure and human resource to properly deal with immunization related safety issues at a national level. **Source:** .Duclos P, Hofmann CA, WHO

**25. NHA Interim Estimation model:** To maximize their usefulness and timeliness, NHA estimates need to include the most reliable and most recent data on government, donor, household, and employer spending on health. Very often, the most recent available data are several years old, and the latest NHA estimate is consequently several years out of date. The principal constraint on development of more timely NHA estimates is the length of time it takes statisticians to process the most recent nationally representative household income and expenditure survey. In extreme cases, the time lag between the administration of a household survey and the estimation of NHA can be as much as four years.

This gap is bound to close as countries progress beyond their first NHA estimate, and as the demand for more up-to-date NHA estimates pushes authorities to conduct more frequent household surveys. Nevertheless, there will very often be a gap of two to three years between survey administration and the availability of data for analysis and for NHA estimation.

The gap between the most recent NHA estimate and the present period, however, presents a problem for policymakers wishing to know how (and whether) to change current programs and policies. Important variables could have changed in the health sector since the last NHA estimate, and it is difficult to estimate the potential impacts of alternative policies when current data are unavailable or incomplete. For the purposes of timely policy analysis, it would be extremely helpful to be able to provide policymakers with an estimate of NHA for the current year, based on some reasonable estimates and/or assumptions about certain variables and parameters for the period since the last estimate of actual NHA flows of funds was completed. This is the purpose of the Interim Estimation Model. The estimates would be revised later once data on actual flows of funds in the health sector for the same 12-month period became available.

The model will initially try and project the most important NHA matrices namely the financial flows from sources to financing agents and flows from financing agents to providers or types of services.

**26. PROFILES:** Created to communicate with policymakers, PROFILES offers a way to engage national leaders in policy dialogue about public health nutrition. PROFILES encourages program planners to examine potential payoffs of alternative program approaches. By learning to manipulate models, and by becoming familiar with the supporting scientific literature, users gain an appreciation of the different functional consequences of malnutrition and the role of different interventions.

In all countries where a the application takes place, PROFILES: raises awareness about nutrition; builds consensus; provides a flexible communication tools; builds capacity; makes nutrition a priority; promotes more comprehensive strategies; leverages new resources; better targets existing resources; promotes coalitions in support of nutrition; develops the leadership skills of nutrition advocates.  
<http://www.aed.org/Projects/profiles.cfm>

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**27. Food Fortification:** Persistent and widespread moderate malnutrition continues to compromise the survival and growth of millions of children. “Hidden hunger” caused by micronutrient deficiencies, especially vitamin A deficiency, has a direct relationship with children’s risk of mortality. WHO has



declared malnutrition to be a contributing factor in more than half of all child deaths, and there is evidence that 83 percent of these nutrition-related deaths are associated with mild and moderate (rather than severe) malnutrition. USAID's nutrition programs aim to prevent malnutrition and micronutrient deficiencies in children and women of reproductive age. The key components of the program are: Promotion of [breastfeeding](#) and appropriate infant feeding; Micronutrient supplementation and food fortification; Community-based nutrition initiatives; Food security initiatives **Source:** [http://www.usaid.gov/our\\_work/global\\_health/mch/ch/techareas/nutrition.html](http://www.usaid.gov/our_work/global_health/mch/ch/techareas/nutrition.html)

**28. Monitoring anti-malarial drug efficacy.** Preventing Malaria drug resistance **against *P. falciparum*.** Revise the current *in vivo* protocol in order to develop a single, globally standardized protocol that outlines procedures for monitoring antimalarial drug efficacy against *P. falciparum* in endemic countries. These include:

- a. Recommend specific modifications that might be used to tailor these methods in accordance with differences in the local epidemiology of malaria, especially transmission intensity;
- b. Modify the current *in vivo* response classification system to allow for a single system usable in all endemic areas;
- c. Clarify areas of the current protocol that are currently ambiguous;
- d. Provide ancillary notes to improve understanding of the test methodology.

The primary intent of the protocol, is the monitoring of drug efficacy over time for strictly programmatic purposes. **Source:** [http://mosquito.who.int/cmc\\_upload/0/000/015/800/200239.html](http://mosquito.who.int/cmc_upload/0/000/015/800/200239.html)

**29. Use of insecticide treated nets (ITNs).** The use of insecticide treated nets (ITNs) is especially targeted for vulnerable populations (pregnant women, children under 5). Insecticide-treated nets (ITNs) are a form of effective vector control, when coverage rates are high and a large proportion of man - biting by local vectors takes place after people have gone to sleep. It can also be used for personal protection. Their use has repeatedly been shown to reduce severe disease and mortality due to malaria in endemic regions. In community-wide trials in several African settings, ITNs have been shown to reduce all-cause mortality by about 20%. **Source:** <http://mosquito.who.int/malariacontrol>

**30. Expand Directly Observed Treatment Short course (DOTS) Strategy** - The internationally recommended approach to TB control is [DOTS](#), an inexpensive strategy that could prevent millions of TB cases and deaths over the coming decade. The DOTS strategy for TB control consists of five key elements:

- government commitment to sustained TB control;
- detection of TB cases through sputum smear microscopy among people with symptoms;
- regular and uninterrupted supply of high-quality anti-TB drugs;
- 6–8 months of regularly supervised treatment (including direct observation of drug-taking for at least the first two months);
- reporting systems to monitor treatment progress and programme performance

**Source:** <http://www.who.int/mediacentre/factsheets/fs104/en/>

**31. Strengthen/expand community based DOTS (CB-DOTS)** - WHO has coordinated the “Community TB care in Africa” project in 8 districts in 6 countries badly affected by TB/HIV (Botswana, Kenya, Malawi, South Africa, Uganda and Zambia). The main focus of the project was community contribution to effective TB care by supporting TB patients throughout treatment until cure (including directly observing the initial phase of treatment). The aim of the project was to demonstrate that decentralizing the provision of TB care beyond health facilities and into the community can contribute to

improving NTP performance. The project outcomes were effectiveness, affordability, cost-effectiveness and acceptability of TB care. The project showed that in a variety of settings, the provision of community care, including the option of community DOT, was typically well received. Treatment outcomes among patients cared for in the community were either equivalent to or (more frequently) improved, compared with patients treated through health facilities. Treatment success rates often reached the global target of 85% (taking into account the frequently high TB case fatality in high HIV prevalence populations).

**Source:** [http://www.who.int/gtb/publications/communityTBcare/tb\\_2002\\_312/tb\\_2003\\_312.pdf](http://www.who.int/gtb/publications/communityTBcare/tb_2002_312/tb_2003_312.pdf)

**32. Prompt health seeking behavior to access effective malaria treatment.**

Access to prompt, effective appropriate treatment is a key element of the Roll Back Malaria strategy and is based on the widespread recognition that untreated falciparum malaria contributes both directly and indirectly to the death of non-immune individuals. It is vital that treatment starts within 24 hours of the onset of symptoms, to prevent progression to severe malaria or death. A strong health system would provide for reliable diagnosis as the basis for optimal treatment. However, in most malaria-endemic areas, access to curative and diagnostic services is limited. The HMM strategy therefore aims to improve the common ineffective self-medication practices that are very common in these endemic countries. **Source:** <http://mosquito.who.int/malariacontrol>

**33. Removal of taxes and tariffs on imported ITNs** - Insecticide-treated nets (ITNs) are the most effective means of preventing malaria in sub-Saharan Africa, according to the World Health Organization. Yet many African households do not have ITNs due to several barriers, one of the most important being cost. At current market prices, low-income African households would have to spend a substantial share of their annual disposable income to purchase an ITN. One way to decrease the retail price of ITNs and increase household use is to eliminate the taxes and tariffs imposed on finished nets, netting materials and insecticides. **Source:**

[http://www.netmarkafrica.org/keyissues/NetMark\\_TechBrief\\_Taxes&Tariffs.pdf](http://www.netmarkafrica.org/keyissues/NetMark_TechBrief_Taxes&Tariffs.pdf)

**34. TB/HIV collaborative program activities** - Analysis of national TB and HIV/AIDS programs, and emerging experience from collaborative TB/HIV sites shows that there are many unexploited potential synergies between TB and HIV/AIDS program objectives and activities. Therefore, these guidelines suggest ways forward for collaboration between HIV/AIDS and tuberculosis programmes for implementing TB/HIV joint activities in support of local health services. It is expected that this will generate further evidence to build on phased implementation of collaborative TB and HIV activities at a country level. These guidelines will be updated, as new evidence of efficiency, affordability, feasibility and cost-effectiveness of TB/HIV interventions becomes available. **Source:**

[http://www.who.int/hiv/pub/prev\\_care/pub31/en/](http://www.who.int/hiv/pub/prev_care/pub31/en/)

**35. Cotrimoxazole preventive therapy (CPT) for co-infected during TB treatment** - HIV fuels the TB epidemic and collaboration between TB and HIV control programmes will be vital to address this growing problem. CPT is one of the 12 collaborative activities (outlined in whose interim policy on collaborative TB/HIV activities).

**Source:** [http://www.who.int/tb/publications/global\\_report/2004/04\\_methods2/en/](http://www.who.int/tb/publications/global_report/2004/04_methods2/en/)

**36. Isoniazid preventive therapy (IPT) for PLWHA without active TB** - HIV fuels the TB epidemic and collaboration between TB and HIV control programmes will be vital to address this growing problem. IPT is one of the 12 collaborative activities (outlined in whose interim policy on collaborative TB/HIV activities). **Source:** [http://www.who.int/tb/publications/global\\_report/2004/04\\_methods2/en/](http://www.who.int/tb/publications/global_report/2004/04_methods2/en/)

**37. Sub-national Health Accounts:** In many countries in the region there is a need to use health accounts to monitor the funding and use of expenditure at the sub-national level especially where there are strong state, provincial or district level administrations where the responsibility for health policy is



shared by both the national and these regional authorities. This often requires the development of “bottom-up” accounts for their own purposes at the decentralized level whether or not national estimates exist.

**38. Safe Motherhood (SM) model:** estimating the impact of maternal health service delivery on maternal mortality. Each year, over 500,000 women die of causes relating to pregnancy and childbirth. Many of these deaths could be prevented through appropriately targeted interventions. Even when there is agreement on the need to reduce maternal mortality, however, many times there is little agreement on which areas could best be improved.

The Safe Motherhood (SM) model is a tool that can be used to improve the understanding of how changes in maternal health services can avoid maternal deaths. Some of the questions the model can ask are:

- Where should effort be focused to yield the greatest reduction in maternal mortality?
- How much would it cost to reach a certain level of maternal mortality?
- How much of a reduction in maternal mortality is feasible in the next few years?
- What can be learned from the performance of a similar country?

The SM model estimates the impact of various scores from the Maternal-Neonatal Program Index (MNPI) on the Maternal Mortality Rate (MMR). The MNPI is an index consisting of 81 different maternal and neonatal health services that have been evaluated by reproductive health experts around the world. The SM model uses the current scores for an individual country to represent the current situation of the delivery of these health services in a country.

Using this part of the SM model alone, it is possible to ask questions about a country’s performance in these areas, as well as ask where there might be room for improvement, and the feasibility of such improvement.

Another set of questions relates to the costs of the interventions contained in the SM model.

The costs of the maternal-neonatal program services are estimated using the World Health Organization’s Mother-Baby Package (MBP) model and other cost information from national strategic plans. The MBP model estimates costs for both the current status of service delivery, and a standard, or ideal, delivery of maternal and neonatal health services in a country. The amount currently spent includes consideration of current practices, coverage rates, and unit costs, while the ideal model estimates the amount that should be spent to reach best practices, ideal coverage rates, and appropriate unit costs. The model calculates direct, recurrent, and capital costs.

The ideal budget is assumed to represent full coverage of all components. Adding money to the current budget thus increases the scores of the program index and this score increase then translates into a decrease in the MMR. The model can therefore be used to make specific recommendations about where efforts should be focused and what resources are required to have the greatest impact on overall maternal mortality.

**39. Hospital resource allocation** – public sector resource allocation is often based on incremental budgeting and there are few systematic attempts in the region even under the medium term expenditure frameworks to allocate resources on the basis of standard or target unit costs for service delivery. A practice of integrating the health service statistics and the financial performance reporting needs to be developed whereby all hospitals produce routine financial management information including overall costs per in-patient day, cost per out-patient visit and other key performance indicators to improve the technical efficiency of services and to set standards for resource allocation.

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**40. Visual Inspection of Cervical Cancer** In most less-developed countries, cervical-cancer screening programmes are small-scale or non-existent. Consequently, there are few opportunities to diagnose precancerous disease, and most patients present with invasive disease at an advanced stage. In some less-developed countries Pap-smear-based screening is available, but usually only in urban areas or in the private health sector that serves a small proportion of the female population. Screening programmes based on Pap smears require technical capabilities and systems for transportation, communication, follow-up, and training that are beyond the capacity of healthcare infrastructure in most less-developed countries. Thus, other methods of cervical-cancer screening provision have been investigated. One such method is visual inspection with acetic acid (VIA). The cervix is washed with acetic acid and then inspected by eye for evidence of disease (also known as cervicospoty, or direct visual inspection). This has potential advantages over traditional screening techniques in poorly-resourced locations--there is immediate feedback of test results to the patient and, importantly, treatment can be provided immediately after the test. **Source:** <http://www.reproline.jhu.edu/english/3cc/3lancet/lanceta.htm>

**41. Constructive Male Involvement in RH** – In many countries, all too often men act in ways that contribute to a variety of public-health problems, such as domestic and sexual violence, sexually transmitted infections, spiraling rates of HIV/AIDS, and high rates of maternal and infant mortality. However, men can and often do, play a critical role in promoting gender equity, preventing violence, and fostering positive sexual and reproductive health outcomes for themselves, their partners, and their families. Spurred by the recognition that men's attitudes and behavior can either undermine or promote sexual and reproductive health, many sexual and reproductive health organizations around the world have launched initiatives to encourage positive male involvement. **Source:** [men as partners-gender equality and men. pdf](#)

**RH needs of vulnerable populations:** Given the many disadvantages associated with displacement and particularly with large camps, donors and relief agencies have been more willing in recent years to provide assistance to people remaining within areas of conflict. It is therefore increasingly important to address the reproductive health needs of these populations. Because of the diversity of situations that may be called "armed conflict", it is not possible to describe a single package of reproductive health interventions for all conflict settings. However a core package of healthy interventions that can be provided and can be found at the following site: **Source:** [http://www.who.int/reproductive-health/publications/RHR\\_0013RH\\_conflict\\_and\\_displacement/RH\\_conflict\\_chapter5.en.html](http://www.who.int/reproductive-health/publications/RHR_0013RH_conflict_and_displacement/RH_conflict_chapter5.en.html)

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## **ANNEX H**

### **FURTHER EXAMPLES OF PARTNER CONTRIBUTIONS**

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Ways in which REDSO/PHN's Regional Partners have addressed health systems needs in specific health areas follows.

#### **MATERNAL AND CHILD HEALTH**

Maternal and Child Health (MCH) activities are seen by a number of respondents as somewhat inadequate in attention and several REDSO/PHN staff expressed that this is an area in which the program wants to expand in the future. As far as Best Practices, the chart above shows that, while 2003 saw a surge in MCH, there were zero in the previous three years and only one since. This is not to say that there has not been any effort in MCH. Graduates of RCQHC's Quality of Care Diploma course have gone on to such pursuits as the development of standards for immunization of women and children in Uganda, which were adopted by the Ugandan MOH and stand to improve quality, reduce vaccine wastage and increase coverage. Another participant from Eritrea initiated a model infection prevention and control program in a maternity unit at a regional referral hospital. Following MOH response to scale up the program, 10 additional health facilities have implemented such a program, with six more facilities planning implementation. In addition, as further described below, the Malaria in Pregnancy program has been very successful in a number of countries.

#### **NUTRITION**

RCQHC has focused its attention on Developing National Nutritional Guidelines for PLW/Affected by HIV/AIDS; Nutritional care and support for people living with HIV/AIDS; Pre-Service Training in Nutrition and HIV/AIDS for Nursing Schools Food and Nutrition Implications of Antiretroviral Therapy in Resource Limited Settings; and HIV/AIDS for Medical Schools, Nutrition Departments and Public Health Departments.

During 2003, Angola and Tanzania developed national guidelines using the RCQHC and CRHCS designed guidelines for the nutritional care of person living with HIV/AIDS (PLWHA). The Ugandan NGO TASO (The AIDS Support Organization) used the RCQHC-CRHCS guidelines to train staff in nutrition for HIV/AIDS clients. Swaziland used their national guidelines to design counseling cards for nurses providing care to PLWHA. The RCQHC published a handbook on the methodology for developing, implementing and monitoring national guidelines on nutrition and HIV/AIDS and disseminated it to national AIDS control program, MOHs, PVOs and public and private stakeholders throughout ESA.

A regional workshop on Food Fortification hosted through ECSAHC and the MOST project led to such recommendations as the development of a regional food fortification regulation and control network, a regional laboratory network and a regional network for production support and fortification training. CAFS has facilitated strategic planning workshops for REDSO supported nutrition coalitions in Kenya, Tanzania and Uganda where they received training in advocacy and fundraising. While no longer directly supported through REDSO, these coalitions

are active and one possible option being considered is to disseminate nutrition/HIV materials and information to them.

## **HEALTH CARE FINANCING**

Many key informants felt that ECSAHC has accomplished a lot in its National Health Accounts (NHA) program, with standards, guidelines and policies being promoted, human resources being trained and materials being developed at country-levels. According to PHN's Health Financing Specialist, the NHA diffusion effort is in its second round, an approach which now calls for its institutionalization in the region, principally through additional training. There are now a number of countries that now boast teams of ten to twelve professionals trained in how to set up a national health account program. There are also efforts contemplated to determine the financial burden of specific diseases and its implications for the delivery of services. ECSAHC has been involved in assessing the impact of Community Base Health Finance (CBHF) schemes and developing baseline indicators to measure CBHF scheme performance.

## **LOGISTICS AND DRUG MANAGEMENT**

In concert with ECSAHC, the Rational Pharmaceutical Management*plus* (RPM*plus*) program works with REDSO/PHN's Regional Logistics Initiative for East and Southern Africa to promote the creation of a regional drug management network. The network is designed to help ensure that drug management issues are on regional agendas and incorporated into national health plans. With support from REDSO/PHN, RPM*plus* also worked through the channels provided by ECSAHC to host an international training course on managing the procurement of pharmaceuticals and medical supplies, with a goal of keeping drug management issues at the forefront.

## **REPRODUCTIVE HEALTH**

Reproductive Health (RH) efforts are quite limited according to a number of respondents, and the chart on 'Better Practices' confirms this. This area appears to be neglected. One example of where Partners have been involved in RH, though, is that RCQHC led regional stakeholders in the design, pre-testing, and finalization of a Gender and Sexual and Reproductive Health Integration Guide to assist MOH and NGO program managers to incorporate gender into RH programs. One MTR interviewee said that there was the need to gear up for more Family Planning efforts with the increasing problem of HIV infection. This call to increase RH activities was echoed by several respondents. In fact, RH is another area in which it was indicated that REDSO/PHN wants to expand and the planned addition of a Reproductive Health Specialist to the team should do a lot in this regards.

## **INFECTIOUS DISEASES**

SO7's Infectious Disease (ID) initiative primarily concentrates on two diseases – malaria and TB. Again, as shown in the chart above, 2004 saw a significant surge of ID Best Practices being introduced. Currently the malaria control focus in REDSO/PHN is on prevention in pregnancy and the use of impregnated bed nets to reduce its impact. The Guide for the Improvement of the Quality of Services for the Control of Malaria during Pregnancy (developed by the RH and ID

divisions of RCQHC) are currently being adapted at the country level. A proposal developed during the post graduate diploma course was the improvement of the quality of services in Zambia using malaria in pregnancy as an entry point with funding and supervision provided by RCQHC. Policy issues advocated for at the country level include the reduction or removal of taxes and tariffs associated with the importation. ECSAHC also conducted an assessment study of prevention and control of malaria in pregnancy in 8 countries and disseminated findings to the Malaria in Pregnancy Network for East and Southern Africa (MIPESA). RCQHC's Quality of Care Course includes two weeks of ID instruction, including malaria. The Centre also provided training to improve quality of malaria control services through a Malaria Short Course which led to the development of country level implementation plans for quality improvement by 23 participants from 8 countries.

ECSAHC undertook a regional review of TB care, management and policy to reduce gender disparities, with policy advocacy activities that will follow to address identified areas of gender bias in TB programming. RCQHC provided quality of care inputs for WHO/AFRO Guidelines for Communicates Directly Observed Treatment Short-Course (CB-DOTS).

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## ANNEX I

### SUGGESTED REDSO/PHN MANAGEMENT SCENARIOS

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As discussed earlier, the principal constraints encountered in REDSO/PHN's current approach to carrying out its three mandates of managing a Regional Program, providing services to missions and support to limited presence countries (LPCs) are:

- ▶ Management of the three partner grants and CA activities is very time consuming and limits PHN's ability to provide meaningful TA, primarily to its Regional Partners and secondarily to the Missions (not to LPCs, which appear to be adequately covered)
- ▶ There is a "bottleneck" effect caused by working with only three partners each of which has limited absorptive capacity to use funds and TA and produce results. All Partners receive OD assistance (primarily to address capacity constraints), and this occupies much of their time (and PHN staff time). Cooperative Agencies work through the same Partners, and their activities are also slowed to some extent by the "bottleneck" effect.
- ▶ Missions are generally unaware of PHN's regional program, but most would like to know more about it, make some input and have their national counterparts receive benefits from regional activities. Most Missions, however, feel that they have little time for more participation in the Regional Program because of their heavy bilateral workloads.
- ▶ Missions believe that PHN TA services are becoming increasingly irrelevant – PHN is perceived as too preoccupied with their regional Programs to provide meaningful and sustained services to Missions. Other sources of effective TA are readily available to Missions.

The following is a discussion of suggested scenarios for PHN's to address these constraints.

#### **ADJUST THE CURRENT PHN MANAGEMENT APPROACH**

There are some reasons to believe that the management intensity of current grants may be reduced in the near future, freeing-up PHN staff for more technical assistance functions. The filling of two vacant PHN positions expected shortly should provide some relief. PHN can also continue to find ways to better distribute the management burden among staff such as was done by assigning one staff person to coordinate/monitor OD functions. The OD work itself is becoming more efficient with TA being centralized under one CA (M&L) and as efforts are being made to simplify the PIVA tool and Partners gain more experience with OD. Similar efficiencies may be expected as Grant Managers and their counterparts gain experience in other aspects of grant implementation. Nevertheless, opportunities should be sought for upgrading PHN grant management skills through the AIDS project management courses.

Last, but certainly not least important, is the presence of new PHN leadership, which is now taking a fresh look at old problems and should be able to improve the management of staff and other resources to achieve Program objectives. The Team feels strongly that those PHN staff persons who possess the technical skills that are highest in demand and most relevant to the program priorities should be relieved as much as possible from grant management duties. Further

management and TA efficiencies could also be achieved if the technical focus of the Regional Program were sharpened, as is suggested earlier under the Task 3 Section of this Report.

The Team is concerned about the apparent gap in communication between REDSO PHN and other USAID missions regarding the Regional Program. Many missions feel that the Program is of minimal value and that PHN bilateral services, while of generally high quality, are not as available as they would like them to be. In part, this tension is inherent in most of USAID's regional programs. But, a lot depends also on the approach taken to manage regional programs. It's probably fair to assume that Regional Program monopolized PHN's attention over the last few years and this contributed to a drift away from bilateral services. PHN could argue, and rightly so, that their clients are regional organizations and by extension their constituencies (Ministries of Health, health NGOs and related national organizations). Missions, per se, are not the "customers" of the Regional Program. So it is not surprising that missions may not be knowledgeable of REDSO's Regional Program.

The diminished use of PHN bilateral services may not only be a supply issue. Missions now appear to have more options (and funds) for obtaining help elsewhere. And, as they point out, they have more control over the quality and timing of services via these other arrangements than is the case when they use PHN services.

Regardless of the circumstances, The Team feels that this communication gap is not healthy. The REDSO mandate - "to manage a regional program shaped by mission programs and GHAI principles." certainly implies some synergy between USAID's regional and bilateral programs. Both PHN and missions may be missing opportunities for collaboration that would benefit their regional and bilateral programs. PHN's new leadership and the anticipated easing of grant management burdens as discussed above should provide PHN with an opportunity to reexamine its bilateral services and foster more dialogue with missions on the regional program. Measures that could be considered in this regard include:

- ▶ Limiting bilateral services to certain fields, ideally to those most relevant to the Regional Program such as health care financing, logistics and drug management, malaria, nutrition, among others, and to those TA services that missions cannot easily find elsewhere. This approach would add more focus to PHN services as well as efficiency in the use of the limited amount of PHN staff time available for bilateral services. Missions would have a clearer idea of what to expect from PHN and PHN would be better equipped to respond in a timely fashion.
- ▶ Renewing and sustaining a dialogue with missions on the regional program and on bilateral services. Missions were clear that they wanted more information, but they wanted it to be practical and not demanding in terms of their staff time. A concerted PHN effort to address this concern now seems appropriate, possibly via an email newsletter, short survey and/or a round of mission visits. Topics could range from identifying the services Missions would most like to have from PHN to obtaining more Mission input as to health priorities that should be on the regional agenda over the next few years. The Missions' perspectives on regional priorities, captured at least annually, would be an important addition to those articulated by PHN's regional Partners based on the interaction they have with their constituencies.

The above measures have more than likely been tried before with varying degrees of success over the last ten years. However the Team believes that the time now seems right to renew efforts and make a formal management commitment to promote more synergy between regional and bilateral efforts and seek greater efficiency in the implementation of REDSO's three mandates. Most of missions that the Team talked to felt that there was room for more collaboration, often citing technical areas such as the regional health care financing effort which added value to their bilateral programs. But their reference point was more often in the past, the Regional Program of five years ago. That being said, the Team does not suggest that any attempt be made to replicate past PHN efforts; today's dynamics are very different.

### **EXPAND THE NUMBER OF REGIONAL PARTNERS AND ENGAGE THE SERVICES OF AN INSTITUTIONAL CONTRACTOR**

This approach puts emphasis on removing the "bottleneck" effect caused by working exclusively through three partners. The Team believes that this approach should be explored quickly. First there is a need to clearly identify the regional activities that fit with SO7 and could benefit from more support (e.g., quality health care training, networking/information exchange, policy development/dissemination, etc). Then, preliminary criteria should be developed to identify and select potential partners – preferably in consultation with current Partners, CAs and possibly Missions. Factors that need to be considered include: a) does the potential partner now perform functions that are consistent with SO7 and could the organization's output be increased with additional resources? b) Alternatively, if the organization does not perform such functions now, is it capable to assume these functions if were given the resources to do so? c) Does the organization have a positive track record as a donor recipient? and d) Can it meet the accounting, reporting and technical output requirements associated with an AID grant or contract?

Significant OD assistance for a new partner is not an option given the few years remaining in the Strategy period.

To accommodate a significant number of new partners and to relieve the bulk of the PHN staff's current grant management responsibilities, the assessment Team avers that PHN should employ an institutional contractor (IC). An IC could handle most grant management and contracting processes and, if necessary, selected TA or training functions. This would enable PHN staff to bring more technical expertise to bear on the regional program and on Mission/LDC requirements. More PHN staff time available for TA work should also provide opportunities to seek more synergy between regional work and services to missions.

Simultaneously, PHN would need to assess the budget implications, projecting expenditures against likely funding availability and determining the program trade-offs, if any, that may be needed to fund an IC. The feasibility of this IC scenario is contingent upon finding new partners, funding availability and timing. If there is a quick determination that funding is available and that potential partners exist, the Team believes there would be sufficient time to select and hire an IC to begin work by October 2005. Once there is a go-ahead decision to employ an IC, PHN should begin to scope-out the details of potential grants/and contracts with its new partners. This will considerably reduce the lag time involved in funding the new partners once the IC becomes operative.

There may also be a middle ground, one that does not require an IC but could accommodate one or two well-established organizations as potential partners. As discussed previously, experienced



organizations are not likely to require extensive PHN management attention. The expected benefits of having these partners may more than offset any additional PHN grant management responsibilities.

## **IDENTIFYING NEW PARTNERS**

While, it is beyond the scope of this assessment for the Team to suggest specific institutions and assess the feasibility of their participation in the Regional Program, we offer the following brief discussion on potential partners.

The Team recognizes that it is unlikely that there are established *regional* organizations dealing *exclusively* with health issues that meet PHN requirements (otherwise, PHN would probably be working with them already). However, there may be regional organizations that focus on management training, applied research, communications and information dissemination, etc., and that could be used to help achieve SO7 objectives. One example is the East and Southern Africa Institute for Management (ESAMI), headquartered in Arusha, Tanzania, which could be asked to provide health training, and be given the TA and funding to do so. One USAID reported that they used ESAMI for health management training. Another option is to identify well-established *national* health service, training or research institutions and ask them to perform some limited services on a regional basis. The advantage of selecting more established regional or national organizations is that they would be in a better position than less experienced organizations to undertake new initiatives, produce results and manage donor funds efficiently

If the above approach to identifying new partners does not yield significant results, there is another approach that could be explored. There may be many potential partners in the Region with limited but relevant capabilities to produce small pieces that would contribute to the achievement of SO7 targets. This would involve the execution of small, performance related AID grants or contracts of short duration (six to twelve months). Potential partners might include established or emerging health service networks; African consultant firms or associations active in the Region (or in one or two countries); an applied research department of a university; or a think tank. The drawback to this approach - small amounts of funds for multiple partners - is that it is very management intensive. It would probably only be feasible if PHN were to use an institutional contractor (IC).

## **INSTITUTIONAL CONTRACTOR (IC): WHAT IS IT AND HOW MIGHT IT OPERATE?**

A USAID mission normally uses an Institutional Contract (IC) to perform project management functions that it cannot do because of its own organizational limitations (e.g., insufficient personnel dedicated to a particular activity, time constraints, etc.). The Mission can delegate to the IC as many functions and responsibilities as it deems necessary and desirable. For example, in PHN's case, the IC could make grants (or other types of contracts), manage them, disburse funds to grantees, amend grants and provide REDSO with periodic financial and program progress reports. PHN could specify the extent to which it wants to be involved in the process (e.g. approving grants and/or TA terms of reference, conducting quarterly progress reviews with Partners/IC, providing direct TA to the Partners, etc). PHN can also assign certain TA functions to the IC such as OD assistance to grantees, impact assessments of selected regional health interventions, helping partners develop an M&E system to track progress under the SO7, etc.

Typically, the IC has an independent office and is physically located near to at least one of the principal grantees.

The feasibility of using an IC in the SO7 Program appears to depend on three factors: 1) the ability of PHN to find new partners; 2) a REDSO determination that new partners (and the activities they are to undertake) will have a significant positive affect on the Regional Program; and 3) there is sufficient time and funds remaining to develop an IC work scope, compete the contract and hire an IC (for a minimum of two years). Most important are the prospects for new partners. Without them, there appears to be little justification for hiring an IC. On the other hand, use of an IC seems necessary if several new partners are to be included in the Program. If new partners and their roles can be identified within the next few months, there should be sufficient time for contracting an IC to start-up by October 2005. Budget realignments need to be examined and trade-offs considered by PHN.